
South Carolina Health and Safety Education Curriculum Standards

**Developed by the
South Carolina Health and Safety
Education Standards Writing Team**

**Adopted by the
South Carolina State Board of Education
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PREFACE

This document, which contains the South Carolina Health and Safety Education Curriculum Standards, presents the basic concepts and justifications of the vision for school health and safety education in the State. Designed and revised by a team of teachers, faculty, and other practitioners in health and safety education, the document sets forth the learning standards for health and safety education and recommendations for policies and actions that can ensure effective implementation of comprehensive health and safety education programs in districts and schools. The standards and recommendations explained here are consistent with the most recent national health education standards and policy recommendations for school health education.

Standards describes what students should know and be able to do in terms of seven knowledge and skill standards with performance indicators for six target content areas. Each of the standards is demonstrated with performance indicators at three grade-level spans: kindergarten through grade five, grades six through eight, and grades nine through twelve. These benchmarks describe performance expectations that all students should fulfill at an acceptable level of performance. This document is not intended to serve as a teaching guide but rather to provide the conceptual structure for developing curricula that are consistent with best practices. This material can provide direction to both policy-makers and teachers with regard to priority and the measurable expectations for children and adolescents.

Why do we continue to stress the necessity of school health and safety education? At this time in our society, effective health and safety education is an increasingly critical component of school programming. Research evidence attests to clear a linkage among health and risk-taking behaviors and school academic success. Many organizations from public and private sectors across the spectrum have called for the improvement of school health education as a national strategy for improving the health of Americans. Parents across America believe that health education, particularly prevention of illegal drug and alcohol use, is one of the most important goals of public education.

Guidelines for assessing accomplishment of standards as well as steps and recommendations for health and safety education program assessment are also included in this document. In our state's efforts to assure educational accountability, the legislatively mandated content of health education should not be omitted.

This health and safety education document was circulated throughout South Carolina for review, and it received strong endorsement. The comments and suggestions that were offered were considered when decisions were made concerning the final document to be submitted to the State Board of Education. Thanks to all concerned individuals for their efforts to improve the health and education of South Carolina's children and youth.

CHAPTER ONE

A Rationale

Staying healthy in today's complex world requires more than "an apple a day." *Brush your teeth! Wash your hands! Stop, look, and listen!* Sound familiar? The routine rules we all learned as children still apply today and will continue to be heard in South Carolina classrooms, but they are not enough. Health and safety education today is more than just a set of rules to be recited like the ABCs or the multiplication tables.

Complex health and social problems require innovative approaches that go beyond simply adding new rules. Telling students to "Just say no!" must develop into the students' knowing not only *how* to say no but also understanding *why* to say no. They must also be given ample opportunity to develop this new skill of saying no. Health and safety skills must be learned and practiced like reading and writing.

What Is Health Education?

Health education, once aimed at providing students with knowledge and awareness about body systems and hygiene, must now address a much broader perspective to include the interaction of that human being with a highly influential social context in a time of rapid change. Students completing a comprehensive health education curriculum should be equipped with a solid health knowledge base, but they must also possess the tools necessary to apply this knowledge wisely. These critical tools are the health performance skills that will enable students to become productive, health-literate members of society.

A committee composed of representatives of the National Professional School Health Education Organizations defined health education as a planned, sequential, prekindergarten to grade twelve curriculum based on students' needs and current health concepts and societal issues. A comprehensive school health instructional program will encompass the following:

- instruction intended to motivate health maintenance and promote wellness and not merely to prevent disease;
- activities to develop decision-making skills and individual responsibility for one's health;
- opportunities for students to develop and demonstrate health-related knowledge, attitudes, and practices; integration of the physical, mental, emotional, and social dimensions of health as the basis for study of other topic areas, such as consumer, environmental, and nutritional health; and

-
- the use of program planning, including formative and summative evaluation procedures, an effective management system, and adequate resources. (National Professional Organizations 1984, 312)

What Is Safety Education?

Injury prevention and safety are areas of health education that address student learning of the concepts and skills to keep safe and prevent injuries that may be unintentional or intentional, including those caused by weapons and personal assault. It includes also skills for emergency response, first aid, and primary treatment of injury. Intentional and unintentional injuries have an enormous impact on South Carolina children and youth.

The National Committee for Injury Prevention and Control defines injury as any unintentional and intentional damage to the body resulting from acute exposure to thermal, chemical, mechanical, or electrical energy or from absence from such essential as heat or oxygen. Unintentional injuries can be grouped into six broad categories:

- motor vehicle crashes,
- injury by machines and weapons,
- poisoning and exposure to toxins,
- falls,
- fire and burns, and
- drowning and suffocation.

Intentional injuries as causes of death consist of two main categories: *homicide*, or violence to others, including personal or weapons assault; and *suicide*, or violence to the self. Prevention skills related to intentional acts and events include skills in anger management, self-discipline, and conflict resolution. They address mental health issues, such as dealing with sadness or depression, and risk awareness in protection from personal and sexual abuse, assaults, and weapon safety.

Safety education often addresses the channel or arena in which injuries may occur: the workplace, at home, on the move, in public places, including school and community environments. Injuries may occur through personal assault and use of weapons in all arenas.

Injuries in the workplace

- job-related falls,
- electric shocks,
- toxic exposure, and
- machinery mishaps.

Injuries at home

- falls,
- burns,
- poisoning,
- suffocation, and
- firearms.

Injuries in public places

- sports and recreation,
- water sports, fishing, and boating,
- farm equipment, and
- events in parks, malls, or school

Injuries on the move

- automobiles
- motorcycles, bicycles, ATVs,
- pedestrian events, and
- public transportation (e.g., planes, boats, and trains).

South Carolina's young people are a natural resource whose health, education, and well-being are of vital concern to the members of every South Carolina community. The common concern over the health and safety of our youth is based on our knowledge that they are at risk for certain diseases, accidents, and trauma that lead to an increase in illness and premature death.

Unintentional injury is the leading cause of death in children and adolescent youth. Injury, whether intentional or unintentional, is the leading cause of hospitalization for South Carolina's children and youth. Many of these injuries—which contribute to increased costs for medical care and insurance—can be prevented, and schools should play an important role in this effort (South Carolina Department of Health and Environmental Control 1998, 30).

What Are Health and Safety Education Curriculum Standards?

Learning standards specify what students should know and be able to do. They involve the knowledge and skills essential to a discipline that students are expected to learn. Those “skills” include the ways of thinking, working, communicating, reasoning, and investigating that characterize each discipline. That “knowledge” includes the most important and enduring ideas, concepts, issues, dilemmas, and information of the discipline. Learning standards are not merely lists of facts; they should be academically sound, broadly conceived, and assessable.

The South Carolina Health and Safety Education Curriculum Standards are designed to provide direction to communities, districts, schools, and teachers toward the development and delivery of high-quality comprehensive school health education. Health education is a required subject for students in South Carolina public schools, and each instructional program should be appropriate for the grade-level setting and effective for the student population in that community.

Health and safety education standards provide the guidance and direction for districts to develop an instructional program geared to the needs of that particular district and community. The standards are not intended to serve as a specific curriculum but rather to establish the structure for the concepts and skills to be addressed in instructional programs. Standards provide a structure that is more specific than traditional health topics and more focused on the skills essential for learning healthful behaviors and

making positive health decisions. When standards are utilized this way, they also provide the basic foundation for developing and implementing assessment criteria for comprehensive school health education.

What Is Known about the Teaching and Learning of Health and Safety?

Many health behaviors are learned by example. Children and youth model what they observe. Sometimes the results are positive, sometimes not. For example, a young child with a mother who smokes may learn to dislike the odor of cigarette smoke and remain a nonsmoker. However, it is more likely that children of parents who smoke will also smoke.

Although negative behaviors can be changed later in life, it is more effective to encourage positive behaviors at the earliest age possible. South Carolina students have a better chance of becoming healthy, productive adults when they receive planned sequential health instruction that focuses on positive health behaviors early in their lives. Instruction that begins while children are young and continues into their youth not only reinforces these behaviors during their adolescence but also enables the positive behaviors to be sustained throughout adulthood.

Professionals in the fields of education and health know a great deal about learning and the dynamics of change. Research-based information about the teaching and learning of health behaviors suggests that education and health are interdependent: healthy children learn better. Learning is an active process, and involvement is inherent in it: individuals learn best from instruction that is hands-on and related to life experiences. Learning is more effective with organized, sequential, age-appropriate instruction than with disorganized, isolated, or piecemeal instruction, and individuals learn best when the task is relevant to the learner. Health education must be a collaborative process among family, school, and community since home, peers, social norms, public policy, social support systems, and mass media influence health behaviors. Teaching involves guiding the learner to and through meaningful experiences. Learning is enhanced when the learner is self-motivated and has a positive self-concept.

While individuals learn best through personal interaction, peer instruction can also have a positive impact on learning. Individuals learn differently, so a variety of teaching methods should be employed. Consistent and repeated messages—along with a multifaceted approach reinforced across all learning environments—are necessary to reinforce health learning. Integrating health topics into other subjects increases health learning. Moreover, significant changes in health knowledge, attitudes, and health practices occur and are maintained with forty to fifty hours of quality classroom instruction each year taught by certified health teachers (Connell et al 1985, Wojtowicz, 1990)

Elements of Effective Health Education Programs

Recent evaluation research has identified the elements of health education programs that are highly effective in preventing or reducing risk-taking behaviors. Where these elements are incorporated in well-implemented instruction, credible evaluations have demonstrated that risk behaviors are delayed and protective behaviors are increased. Health education programs that work include the following elements:

- They are founded and grounded in sound social learning theory and thus include
 - skills for inoculation, or resistance, to pressure;
 - health belief constructs leading to action; and
 - the prevention skills of modeling, personalization, training, and situational practice.
- They are specific about the protection behaviors to practice and the risk behaviors to avoid.
- They provide clear, accurate, and factual health and medical information.
- They include activities that address peer, social, and mass media influences on behaviors.
- They reinforce clear and appropriate norms for protective behaviors.
- They last long enough for students to learn and practice protection and risk-reduction skills.
- They are age, gender, and developmentally and culturally appropriate.
- They engage students by using a variety of teaching methods and activities.
- They reinforce skills and information over time.
- They are taught by trained teachers and/or peer facilitators (Kirby 1998, 28-30).

The Rationale for Change

By any measure, the health status of many South Carolinians is impaired. Poor health is related to lower academic achievement, decreased productivity, and increased costs to society. Substance abuse, poor nutrition, inadequate physical activity, teen pregnancy, HIV and other sexually transmitted diseases, emotional stress, injuries, and violence are contributing factors to the overall poor health status of students and to their lack of academic success. Many of the poor health conditions are rooted in risk behaviors and unhealthy lifestyle habits and thus are preventable and correctable.

According to the *KIDS COUNT Data Book 1999: State Profiles of Child Well-Being*, South Carolina ranks forty-fifth in overall life and health status of children. While

improvement has occurred in some indicators over the last decade, such as infant mortality, critical indicators, such as child and teen death rates, single parent families, and percentage of teens that have dropped out of school have worsened. South Carolina's rates on key indicators and ranking in the nation are shown in the chart below.

Table 1
KIDS COUNT Status and State Ranking:
Comparison between South Carolina and the United States

INDICATOR	S.C.	U.S.	S.C.'s Rank
Percent low birth weight babies	9.2	7.4	47
Infant death rate/1000 births	8.4	7.3	38
Child death rate/100,000	39.0	26.0	49
Teen death rate by accident, homicide or suicide/100,000	75.0	62.0	35
Rate of births to teens/1000 (ages 15–17)	41.0	34.0	39
Percent of teens who are high school dropouts (ages 16–19)	11.0	10.0	35
Percent of children in poverty	24.0	20.0	39
Percent of single parent families	31.0	27.0	43
Percent of children without health insurance	17.0	14.0	40

The publication *Health of South Carolinians* (South Carolina Department of Health and Environmental Control 1998, 32) identifies four critical health concerns as the leading causes of death, hospitalization, and disability for children and teenagers. Targeted educational efforts have the potential to reduce each of these threats.

Unintentional injuries are the primary cause of death and hospitalizations for both children and teenagers. Motor vehicle crashes, falls, and fires are major causes with drowning deaths also prevalent. The motor vehicle crash death rate for teens has been increasing, with alcohol use, speeding, and the failure to wear seat belts as contributing factors.

Homicide and suicide death rates for children and youth have increased, and the rates in South Carolina are higher than the national rates. Males are at greater risk for suicide, with guns being the weapon of choice. Of considerable concern is the percentage of teens who confront the possibility of committing suicide: one in five has considered it, one in six has planned it, and one in ten has attempted it.

Adolescent pregnancy in South Carolina remains a continuing problem: one in twenty-five girls will become pregnant before her eighteenth birthday; 70 percent of these teen births are to single mothers. Too early motherhood adversely affects the lives of both the infant and the mother. Although the teen rates of sexual activity, pregnancy, and births have steadily declined over the last decade, the sexual activity rates still place teenagers at increased risk of pregnancy, sexually transmitted diseases, and HIV infection. To date, over five hundred South Carolina teenagers have been diagnosed with HIV infection, and more than half of them are female.

Substance abuse is a contributing factor in sexual activity and HIV infection. It also is the leading contributor to motor vehicle deaths and injuries for adolescents. The risk behavior data show alcohol use prevalent and unchanging through the decade, with more than 70 percent of teens reporting use. In addition, the 1990s saw large increases in marijuana and tobacco use, and in 1999 nearly half of teens reported using it. Reported cocaine use, which had been very low throughout the decade, doubled in 1999.

The 1999 South Carolina Youth Risk Behavior Survey, conducted by the University of South Carolina School of Public Health with a grant from the South Carolina Department of Education (SDE) assessed risk-related behaviors of adolescents for that year. This survey, which biannually questions students in grades nine through twelve, documents alarming levels of tobacco, alcohol, and other drug use; possession of weapons; early sexual activity; and attempted suicide among high school students. Some of these data are reflected in table 2. The deaths, injuries, and illnesses identified in these statistics reflect serious threats to the lives and health of South Carolina's students, but these risks can be prevented.

Priority Health-Risk Behavior

The Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH) has identified six categories of health-risk behaviors that are most detrimental to adolescents. These behaviors are the primary causes of the most prevalent health problems of teenagers. They include tobacco use, poor nutritional choices, and lack of physical activity as the precursor behaviors for the leading chronic diseases: cardiovascular disease and cancer. These behaviors are also interrelated. Youth who engage in one risk behavior are more likely to engage in others, and the skills for preventing or reducing risk behaviors are similar across the categories (Symonds 1997, 220). Dr. Lloyd Kolbe, DASH director, clearly cites the six types of behaviors that are most detrimental to the health of adolescents as the targets for school health education:

- behaviors that result in unintentional or intentional injuries;
- use of alcohol and other drugs;
- sexual behaviors that result in HIV infection, other sexually transmitted diseases, or unintended pregnancy;
- use of tobacco;
- poor nutritional choices; and
- insufficient physical activity. (Kolbe 1990, 44)

These interrelated behaviors contribute to the major health problems facing our country and state. They contribute to premature death and disability, and they result in spiraling health and medical care costs in addition to welfare costs and lost productivity. These also are the risk behaviors that contribute to low test scores and school failure, school dropout, and lost educational potential. It is therefore most logical that these six priority risk behaviors be the target of health education.

For the first time in the history of this country, young people are less healthy and less prepared to take their places in society than were their parents.

—National Commission on the Role of the School and Community in Improving Adolescent Health/National Association of State Boards of Education and the American Medical Association, 1990

Table 2**1999 South Carolina Youth Risk Behavior Survey Summary Findings**

Percentage of S.C. High School Students
Who Display Risk-Taking Behaviors

RISK BEHAVIOR	PERCENT
Rarely or never wore a seatbelt when riding in a car	20.9
In the past month, rode with a driver who had been drinking alcohol	34.6
In the past month, carried a weapon	21.7
Attempted suicide in the past year	7.9
Smoked one or more cigarettes in the past month	36.0
Drank alcohol at least once in the past month	45.4
Used marijuana at least once in the past month	24.5
Ever had sexual intercourse	58.1
Were sexually active and did not use a condom during last sexual intercourse	38.8
Did not participate in vigorous physical activity on three or more days in the past week	44.8
Did not attend PE class daily	81.9
Were overweight	10.7
Did not eat five or more fruits and vegetables per day	17.6

Reversing the Trend

Each decade since the 1970s the U.S. Public Health Service has established specific national health goals, and its 1990 publication *Healthy People 2000* identified goals to be attained by the end of this century. About a third of these goals focus on reducing priority risk behaviors of children and youth and improving school health programs. One of the National Education Goals specifically addresses the objective that every school in America will be free of drugs and violence and will offer a disciplined environment conducive to learning. (Secretary's Commission on Achieving Necessary Skills, 1991)

Families, communities, and businesses have begun to work together with the schools to address total community health and provide a safety net to support children and create for them a health-enhancing environment in schools and communities. Federal policy, the 21st Century Learning Centers program, has provided major funding for health and academic after-school initiatives.

The South Carolina General Assembly moved aggressively to set in motion the reforms that would enable our schools and our students to meet the nation's objectives and to mesh educational, health, and social service interests to better coordinate delivery of services to school-aged children. In 1996, the General Assembly enacted legislation that now calls for a system to coordinate interagency funds to support health, social, and education services to children and families. [S.C. Code Ann. § 59-141-10 (C)(g) (1990)].

The potential cost-effectiveness of prevention programs is well documented. The increasing costs of health care demand greater collaboration among private and public institutions. The concept of primary prevention has been promoted through interagency collaboration. These primary prevention programs are defined as those that "seek to prevent the onset of disease, disability, or high-risk behaviors through the enhancement of individual and community protective factors and the reduction of risk factors" (Kolbe 1994, 554).

South Carolina law currently mandates comprehensive health education. Recognizing its importance, the South Carolina General Assembly approved the Comprehensive Health Education Act in 1988. It was intended to foster health-related skills, attitudes, and practices in children and youth. Although there has been progress, the legislation has not completely fulfilled its potential. Implementation efforts vary from district to district and from school to school. Results from the 1996 and 1998 South Carolina School Health Education Profile Surveys show some improvements in the delivery of health education, including increases in cooperative health promotion activities and support for professional development. Parent feedback and public support remains favorable. However, more than 30 percent of the lead teachers of health in middle and high schools are not certified in health education, and twenty-five percent of secondary principals report that health education is not required in their schools.

The Comprehensive Health Education Act brought health education to the forefront and defined its parameters. It gave authorization to the efforts of health professionals and recognition that the content was important. Two major statewide studies (one in 1987, which was prior to passage of the act, and one in 1997) demonstrated clearly the continued high levels of public support for the contents of comprehensive health education. In the 1997 study, for example, 96 percent of registered voters supported the AIDS and sexuality content (Lindley and Reininger 1997).

With such high levels of public support, it is clearly time for the health education needs of our students and their families to be given the priority they deserve. These concerns demand that the school health program become a central area of attention. Priority in health education calls for leadership from health educators and other health professions and needs the commitment of families, communities, business, government, and the educational system. Health and safety instruction, focusing on the health and wellness

of children and youth, must become an integral and consistent part of the total school program.

Other initiatives in South Carolina—such as the Early Childhood Development and Academic Assistance Act, the School-to-Work Transition Act, and First Steps— focus on increasing students' in school. The Schoolhouse Safety Alliance Act, which increased funding for school resource officers, addresses the prevention of school violence. The federal Safe and Drug-Free Schools Program provides resources for addressing substance use and safety education. The continued effectiveness of such legislation and initiatives may well depend on our addressing the health behaviors of students and their families.

All South Carolina students should have the opportunity to learn. However, their capacity for succeeding in school is diminished significantly if they are absent, or are hungry or distracted by unhealthy behaviors or hazardous situations. The Health and Safety Education Curriculum Standards represent a commitment to improving the health and safety of South Carolina students. Health-literate students will have the capacity to obtain, interpret, and use basic health information and skills in ways that enhance their health.

Reversing the trend of impaired health and safety in South Carolina requires schools, families, and communities to make a commitment to the health and well-being of children and youth. It also dictates increased emphasis on the knowledge, skills, and behaviors that are requisite for healthy living. Priority status must be given to health literacy just as it is to mathematical, scientific, and linguistic literacy.

South Carolina's response must be immediate and comprehensive. The State's school systems must design and implement quality health and safety instructional programs in a coordinated school health context that promotes improved health for all students. The purpose of the Health and Safety Education Curriculum Standards is to provide for the development of instructional programs that produce health-literate citizens. To achieve health literacy, health and safety education must equip students with the knowledge and skills necessary to make lifelong, health-enhancing choices that demonstrate responsibility to self and others. To accomplish that purpose, the traditional emphases of health education must shift the focus to best practice activities that have been shown to develop the skills of health literacy.

CHANGING THE EMPHASES OF HEALTH EDUCATION
TO PROMOTE HEALTH LITERACY

LESS EMPHASIS ON	MORE EMPHASIS ON
Activities that focus on health content	Activities that provide practice in using content to apply health skills
Activities confined to one class period	Activities over extended periods of time
Processing skills out of context	Processing skills in context
Getting an answer	Using skills to develop a healthy lifestyle
Doing few activities in order to leave time to cover large amounts of content	Doing more activities to develop understanding, knowledge of health content, and health skills

From the CCSSO-SCASS Health Education Assessment Project, 1998.

The health of the people is really the foundation upon which all their happiness and all their powers depend.

—Benjamin Disraeli, Prime Minister of England, 1874–80

CHAPTER TWO

A NEW PERSPECTIVE

What is Health Literacy?

According to the Joint Committee on Health Education Terminology, health literacy for students is the “capacity of an individual to obtain, interpret, and understand basic health information and services and the competence and skills to use such information and services in ways which are health enhancing” (Joint Committee 1991, p. 99). The learning standards in this document have the goal that every student in South Carolina become health literate.

Health-literate people exhibit the following four characteristics:

- **Critical thinking and problem-solving skills.** Health-literate individuals are able to identify and address personal health problems and issues at an appropriate level. They have the ability to use various sources of information and services for making sound rational decisions for ensuring an optimum quality of life.
- **Responsible, productive citizenship.** Health-literate individuals acknowledge their obligation to assure that their community is kept healthy, safe, and secure. They also realize that this obligation begins with the self and with incorporating health-related knowledge into everyday behavior. Responsible individuals value themselves and avoid behaviors that pose a health or safety threat to themselves, to others, or to the environment.
- **Self-directed learning.** Health-literate individuals assume personal responsibility for their own health and wellness. They assess their own well-being, gather current information, evaluate changing health promotion and disease prevention issues, and apply this knowledge to achieve a higher level of wellness.
- **Effective communication:** Health-literate individuals effectively convey beliefs, ideas, and information about personal and community health. They utilize health information, products, and services and advocate for positions, policies, and programs that are in the best interest of society. They also use interpersonal and social skills to maintain healthy relationships.

How Can School Health and Safety Education Be Most Effective?

School health programs for children and youth are most effective when they coordinate the elements that most influence the life and learning of children. The vision for preparing productive, contributing members for a complex, rapidly changing society will be reached with approaches that involve families and communities working in collaboration with schools.

Many factors contribute to the poor health status of South Carolina's students and influence whether or not a child will be healthy and will maintain a lifelong commitment to health. These factors include economic disadvantage, neighborhood disintegration, poor family-management practices, peers and family who use alcohol and other drugs, low expectations for children's success, and academic failure. However, there are also factors that buffer and reduce risks in children's lives. They include having opportunities to practice health-related skills, having clearly defined expectations and norms for appropriate behavior at school and at home, having opportunities for service and contribution, and receiving recognition for participation in positive activities and personal accomplishments. Health and safety education is enhanced in a program context that addresses multiple prevention and intervention activities in a planned and coordinated manner.

School health and safety education can be most effective when it is coordinated in a planned and systematic way with other related health and safety school health program components:

- skills-based health and safety education;
- physical education and activity;
- healthy and safe school and community environment;
- family, business, and community involvement;
- staff health and wellness promotion;
- school food services;
- guidance/counseling, psychological, and social services; and
- school health services.

Each of these components includes programs, policies, procedures, and activities that are intended to promote and protect the health and well-being of the school community. They have been described as the "safety net" that supports and endeavors to assure that all students can have the best chance to profit from the educational opportunity afforded them.

Clearly for health education to be effective, students need more than isolated health messages delivered by a single teacher on a rainy Friday afternoon or even during a one-semester health course. Instruction must focus on the development of life skills that promote good health. Students must be actively engaged in a variety of learning experiences that provide them with opportunities to practice and reinforce those skills both in and out of school.

Health education skills are best learned when reinforced by a healthy school environment. Good health should be modeled every day throughout the school—nutrition in the lunchroom, physical activity on the campus, safety in the halls,

restrooms, at the crosswalks, and athletic events. Faculty and staff are important role models in the promotion of good student health. School-site health promotion programs for staff provide obvious personal benefits as well as enhance the teaching/learning process. Clear policies for responsible discipline, tobacco-free campuses, and healthy selections in vending machines and canteens contribute to an environment that supports and enhances good health.

A coordinated school health program also delivers services to meet the needs of the student population. Services such as screening, referrals, guidance and counseling, psychological and social service, and school health services all address the specific needs of students. Finally, a coordinated school health program will provide families, as well as businesses and the community, with opportunities to ensure that every student is given the chance to learn the skills necessary to become a health-literate individual.

A Coordinated Approach

The following descriptions of these eight components help to define the broad scope of health and safety education in the context of a coordinated approach to school health.

Skills-Based Health and Safety Instruction

Health instruction should motivate and enable students to maintain and improve their health and not merely to avoid risks or prevent disease. A planned, sequential preK–12 health curriculum provides structured and age-appropriate experiences to assure students acquire relevant, scientifically accurate knowledge about health. It provides for the development and practice of skills needed to support health-enhancing attitudes, beliefs, and behaviors. Priority areas appropriate for the developmental stage and potential for risks should be targeted in the content. As best practice, health education should be scheduled at each grade level for at least fifty hours of instruction annually and should be taught by qualified, adequately prepared teachers. Proven effective, research-based curricula and appropriate instructional strategies should be used to actively engage students in the learning process.

Physical Education and Fitness

A planned, sequential, age-appropriate prekindergarten through grade twelve physical education curriculum provides skill learning in the variety of movement activities and health-related fitness activities that promote lifelong physically active lifestyles. Quality physical education promotes each student's optimum physical, mental, emotional, and social development. Health concepts related to fitness, nutrition, weight control, stress management, effects of substance abuse, injury prevention, and safety can be integrated and reinforced in the physical education curriculum.

Healthy and Safe School Environment

A healthy school environment includes all the physical surroundings and the psychological climate in which students, faculty, and staff work. Factors that influence

the physical environment include the school building, the area surrounding it, playgrounds and athletic fields, biological or chemical agents that may be detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychological environment includes the interrelated physical, emotional, and social conditions that affect the well-being and productivity of students and staff. These include physical and psychological safety, positive interpersonal relationships, and recognition of the needs, worth, and successes of students and school personnel. Administrative policies, both formal and informal, and the school community should support the establishment and maintenance of a healthy and safe environment. School resource officers connect to the community and contribute to safe and substance free school environments.

Family, Business, and Community Involvement

Coordinating community resources and services with programming and facilities in the school improves the ability of both the community and the school to meet the needs of students and their families. Such collaborations increase the quantity and quality of school health and wellness promotion efforts, redefine institutional roles, and reduce fragmentation and duplication of services. Schools must encourage and actively pursue parent involvement and provide parent education about relevant health topics. Local organizations, working with the schools, can provide service projects and opportunities that involve and engage students in contributing to their community.

Staff Health and Wellness Promotion

A staff health and wellness promotion program encourages and motivates all school staff to pursue a healthy lifestyle. It promotes better health, improved morale, and a greater personal commitment to the school's comprehensive health program. Facilities and schedules should promote opportunities for health assessment, health education, and health-promoting activities. Specific activities might address nutrition, physical activity, stress and time management, conflict resolution, or smoking cessation. Wellness promotion programs have been shown to improve faculty and staff productivity, decrease absenteeism, and reduce health insurance costs.

School Food Services

School food services promote the health and education of students by providing them access to a variety of nutritionally balanced and appealing meals that reflect the principles outlined in the *Dietary Guidelines for Americans*. The school cafeteria may serve as a learning laboratory for classroom nutrition and health education and reinforce the concepts taught regarding the selection of healthy foods and the adoption of health-enhancing nutritional habits. A school food service may function as a resource for linkages with nutrition-related community services and may be effectively utilized as an opportunity for parental and community participation in school activities.

Guidance Counseling, Psychological Services, and Social Services

These services consist of assessments, interventions, and referrals that address the mental, emotional, and social health needs of students. The developmental guidance

and consultation skills of counselors and psychologists contribute to the overall health of students and to the healthy psychosocial environment of the school. Intervention programs may be broad-based and include assertiveness training, life skills training, peer-led discussions, problem-solving training, and programs that address esteem, coping strategies, and personal and family concerns. Guidance counselors, psychologists, mental health specialists, and social workers also connect families and community-based providers to meet the mental health and social service needs of students.

School Health Services

School health services provide appraisal, identification, intervention, and management of health problems that may interfere with learning. This assistance may include assessment and early detection of disease and other health problems, as well as referral to primary health care services. It may also include monitoring students with special medical needs and providing emergency care for illness or injury. In addition, school health services work to promote safe and sanitary conditions within the school environment and to provide educational and counseling opportunities that maintain and foster the health of students, families, and the community as a whole. Health personnel may also provide reinforcement for health instruction and provide leadership for school and community activities that promote healthy lifestyles for students and staff. Services are generally provided by qualified school nurses, but schools also use dentists, physicians, community health educators, and other allied health personnel.

The groundwork for change is in place in South Carolina. Problems have been identified, and the foundations for interagency collaboration have been established. The law mandates health instruction, and communities are recognizing their role in health promotion. Now it is clear that all parties in the State must begin to work together to produce community of health-literate individuals who will create a healthier South Carolina. The goal of these standards is for every student in South Carolina to become health literate.

**The vision for
health and safety education
in South Carolina's schools,
in partnership with families and communities, is
for every student to become health literate.**

**Health and safety education must equip students
with the knowledge and skills necessary
to make lifelong, health-enhancing choices
that demonstrate responsibility to self and others.**

The health of nations is more important than the wealth of nations.

—Will Durant, American historian and essayist (1885–1981)

CHAPTER THREE

STANDARDS FOR HEALTH AND SAFETY INSTRUCTION

For several decades, health education curricula have addressed from ten to fifteen traditional health topics. This construct has contributed to fragmented instruction and a lack of attention to skills. Cumulative research has demonstrated the interrelatedness of health risk behaviors and the effectiveness of skills-based health education in reducing risk behaviors and enhancing protective behaviors. The standards-based approach introduced with the publication of the *National Health Education Learning Standards* in 1996 fused health and safety concepts with essential skills. The learning standards are interwoven to create an integrated skills-based approach to health and safety instruction. They provide direction for communities and school systems to develop a responsive local health education program that promotes health literacy for all students. This shift from the traditional focus on health topics to the expanded emphasis on health and safety standards and skills serves to connect, rather than fragment, health and safety instruction.

Integrating Learning Standards into Target Content Areas

The *South Carolina Health and Safety Education Curriculum Standards* describes seven standards that identify what students should know and be able to do. Student knowledge and skills are the appropriate focus. It is not the intent of health education practitioners to evaluate individual students on their health status or grade them on whether or not they have made health behavior changes. Such is not the case with other disciplines: social studies students are not graded on whether they vote, and math students are not judged by whether or not their checkbooks balance. Rather, health education assessment measures gains in knowledge and skills. These standards, based on the National Health Education Standards, state that students should be able to acquire the following knowledge and skills at the end of three grade-level spans (kindergarten through grade five, grades six through eight, and grades nine through twelve).

In the larger context, schools are society's vehicle for providing young people with the tools for successful adulthood. Perhaps no tool is more essential than good health.

Council of Chief State School Officers, 1995

The Learning Standards

1. Students will comprehend health promotion and disease prevention concepts.
2. Students will demonstrate the ability to access valid health information, products, and services.
3. Students will demonstrate the ability to practice behaviors that enhance health and reduce risks.
4. Students will analyze the influence of personal beliefs, culture, mass media, technology, and other factors on health.
5. Students will demonstrate the ability to use interpersonal communication skills to enhance health.
6. Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.
7. Students will demonstrate the ability to advocate for personal, family, and community health.

Content Areas

This document also identifies six target content areas in which students should work to fulfill each standard:

- I. Personal Health and Wellness
- II. Nutritional Choices
- III. Mental Health
- IV. Preventing Injuries
- V. Family Living and Healthy Sexuality
- VI. Alcohol, Tobacco, and Other Drugs

Performance Indicators

Performance indicators benchmark how students should demonstrate their achievement. They are stated for the end of three grade spans according to the target content area in which the students are working. Performance indicators are more specific illustrations of the material and ideas implied by the learning standards. They state specific concepts and skills that fifth-, eighth-, and twelfth-grade students should know and be able to do to demonstrate achievement of the health and safety education standards. Because the learning standards tend to be broad statements of intent, performance indicators will show specific applications of the standards in more measurable terms and for specific target content areas. They are broadly stated to allow flexibility in selection of instruction and materials, but they are specific enough to

provide clear direction. Taken as a group, the performance indicators for a specific learning standard will demonstrate most, but perhaps not all, of the ways in which the learning standard can be further defined. They are intended to help educators focus on the essential knowledge and skills basic to the development of health-literate students. The performance indicators serve as the blueprint for organizing the health and safety curriculum and student assessment.

Comprehensive school health education offers the opportunity for us to provide the knowledge and instruction necessary to enable children to be productive learners and to develop the skills to make health decisions for the rest of their lives.

—National School Boards Association, 1995

The Rationale for Each Target Content Area

I. Personal Health and Wellness

Seven of the ten leading causes of death are related to personal behavior and lifestyle choices. Physical wellness and personal responsibility for the practice of health-enhancing behaviors are basic components of health. Students learn personal health skills best in an environment that supports the development and maintenance of positive health behaviors as well as an understanding of the causes, effects, prevention, and treatment of diseases.

II. Nutritional Choices

An effective nutrition education program will contribute to lifelong health. Diverse nutrition practices and changing nutritional needs throughout the life cycle require balancing daily food intake with energy expenditure. Healthy eating habits reduce the risks of developing chronic diseases and health problems.

III. Mental Health

A positive self-image is an important component of mental health. Emotional health includes the ability to express needs, wants, and feelings; to handle emotions in positive ways; and to manage anger, conflict, and frustration. Stress management provides the coping skills for maintaining sound mental health. Interpersonal communication skills promote social health by building and maintaining healthy relationships.

IV. Preventing Injuries

Whether measured in the number of deaths, in the dollar costs for treatment, or in the loss of potential years of life, injury ranks highest among health problems affecting children and youth and is the leading cause of death among them. Violent and self-destructive behaviors significantly contribute to these deaths in the school-aged population. Effective safety education promotes beliefs and practices that enable students to avoid and reduce the risk of injuries that occur on streets and highways and in the workplace, home, and school.

V. Family Living and Healthy Sexuality

Emphasis on the rights and responsibilities of family members; on understanding, accepting, and managing one's sexuality; and on acquiring the skills that promote abstinence and positive family involvement will contribute to improved health of the individual, families, and society.

VI. Alcohol, Tobacco, and Other Drugs

Substance abuse pervades our society, and students must understand its lifelong physical, emotional, social, and economic consequences. They must develop skills for resisting peer, social, and mass media influences on these personal choices.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 1: Comprehend health promotion and disease prevention concepts.

By the end of grade five, students should be able to

- identify personal practices that promote health and safety (e.g., hand-washing and other forms of personal hygiene and preventive health behaviors);
- identify the structure and functions of the major systems of the human body;
- identify health problems that should be detected and treated early;
- give reasons healthy behaviors prevent disease; and
- explain how the environment affects health.

By the end of grade eight, students should be able to

- describe how lifestyle behaviors, environment, genetics, and medical care influence health;
- explain how disease processes affect body systems;
- compare and contrast strategies for reducing the risks of communicable and chronic diseases; and
- describe the components of a personal health program.

By the end of grade twelve, students should be able to

- evaluate risk relationships between healthy lifestyle behaviors and disease prevention;
- analyze strategies for detection and treatment of communicable and chronic diseases; and
- evaluate the risks and benefits of personal health practices.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 2: Access valid health information, products, and services.

By the end of grade five, students should be able to

- find health information, products, and services that promote personal hygiene, wellness, disease prevention, and environmental health and
- cite ways of knowing whether or not health information, products, and services are valid and reliable.

By the end of grade eight, students should be able to

- analyze the validity of health information, products, and services;
- demonstrate the ability to utilize school and community resources that provide valid health information, products, and services; and
- demonstrate the ability to access resources and services that promote a safe and healthy environment.

By the end of grade twelve, students should be able to

- evaluate the validity of health information, products, and services from community agency, technology (Internet), and mass media sources;
- evaluate factors that influence personal selection of health products and services;
- demonstrate the ability to access school and community health services;
- analyze the cost and accessibility of medical care services; and
- evaluate resources and services that promote a safe and healthy environment.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 3: Demonstrate the ability to practice behaviors that enhance health and reduce risks.

By the end of grade five, students should be able to

- demonstrate strategies for accepting responsibility for personal health behaviors and
- demonstrate strategies to improve or maintain personal health, dental care, hygiene, wellness, fitness, and disease prevention.

By the end of grade eight, students should be able to

- demonstrate strategies for personal health maintenance and enhancement and
- demonstrate strategies for detection and treatment of common health problems and communicable and chronic diseases.

By the end of grade twelve, students should be able to

- demonstrate the ability to use primary care prevention strategies for maintaining and enhancing health;
- design and evaluate a health and wellness plan that is adaptable to changing needs; and
- develop a plan for using health resources for the prevention of and intervention in various diseases.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 4: Analyze the influence of personal beliefs, culture, mass media, technology, and other factors on health.

By the end of grade five, students should be able to

- give examples of how various factors influence health choices (e.g., personal, cultural, mass media, technology, peer, family) and
- describe how physical, social, and emotional environments influence personal health and well-being.

By the end of grade eight, students should be able to

- analyze the influence of peers, family, and mass media on health behaviors;
- describe the influence of cultural beliefs on health and the use of health services; and
- analyze the influence of technology and the environment on personal health.

By the end of grade twelve, students should be able to

- analyze how the environment influences the health of the community;
- describe how public health policies and government regulations influence health promotion and disease prevention; and
- analyze how research, technology, and medical advances influence the prevention and control of health problems.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 5: Use interpersonal communication skills to enhance health.

By the end of grade five, students should be able to

- demonstrate the ability to ask for assistance in improving health and dealing with common health problems.

By the end of grade eight, students should be able to

- demonstrate effective verbal and nonverbal communication skills to enhance health and access personal health services.

By the end of grade twelve, students should be able to

- use strategies to overcome barriers to communication about health issues;
- demonstrate refusal and negotiation skills to enhance health and reduce risks; and
- demonstrate effective verbal and nonverbal communication skills to enhance health.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 6: Use goal-setting and decision-making skills to enhance health.

By the end of grade five, students should be able to

- demonstrate the ability to apply a decision-making process to health issues and problems;
- determine when health problems require adult assistance; and
- set a personal health goal, track progress, and assess achievement.

By the end of grade eight, students should be able to

- predict how decisions regarding health behaviors have consequences for the self, for others, and for the environment;
- demonstrate the ability to assess personal health strengths and weaknesses; and
- demonstrate the ability to develop and implement a personal health and wellness program.

By the end of grade twelve, students should be able to

- demonstrate the ability to use various strategies when making decisions related to health needs;
- evaluate a personal health assessment to determine strategies for health enhancement and risk reduction; and
- design, implement, and evaluate a personal plan for lifelong health and wellness.

Content Area I: Personal Health and Wellness

Content Area I: Personal Health and Wellness

Standard 7: Demonstrate the ability to advocate for personal, family, and community health.

By the end of grade five, students should be able to

- explain ways or strategies to influence and support others in making positive health choices.

By the end of grade eight, students should be able to

- demonstrate the ability to influence and support others in promoting a healthy environment and
- demonstrate the ability to use a variety of methods to disseminate valid health information.

By the end of grade twelve, students should be able to

- evaluate the effectiveness of a health promotion campaign for accurate communication;
- demonstrate the ability to adapt health messages and communication techniques to the characteristics of a particular audience; and
- analyze community strategies for preventing or reducing the spread of disease.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 1: Comprehend health promotion and disease prevention concepts.

By the end of grade five, students should be able to

- classify foods by their type, function, and nutritional content;
- explain the short and long-term benefits and risks of nutritional choices;
- explain the structure and function of the digestive system; and
- recognize the relationship among food intake, physical activity, and health.

By the end of grade eight, students should be able to

- describe the relationship between proper nutrition and food handling and the prevention of disease and premature death;
- describe the relationships of food selection to body composition, energy expenditure, and health;
- describe the adverse effects of eating disorders; and
- describe the adverse effects of high dietary fat intake.

By the end of grade twelve, students should be able to

- discuss the effects of nutrition on appearance and on physical and mental performance;
- analyze the consequences of poor nutritional choices;
- analyze current dietary recommendations for reducing disease risk; and
- analyze varying nutritional needs based on life cycle changes and circumstances.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 2: Access valid health information, products, and services.

By the end of grade five, students should be able to

- demonstrate the ability to locate valid nutrition information (e.g., food labels, *Dietary Guidelines for Americans*, Food Guide Pyramid, school nutrition services).
- use the *Dietary Guidelines for Americans* and the Food Guide Pyramid as guides for making healthy food choices;
- describe reliable sources of nutrition information; and
- demonstrate the ability to locate community nutrition-related resources.

By the end of grade eight, students should be able to

- compare the validity of nutrition information from a variety of sources, including mass media and the Internet;
- demonstrate the ability to locate nutrition services and products that are cost-effective, safe, and appropriate; and
- describe situations requiring the intervention of professional nutrition services.

By the end of grade twelve, students should be able to

- evaluate the validity of nutrition information, recommendations, products, and services;
- analyze factors that influence cost, quality, availability, and selection of a variety of foods; and
- use current research to recommend changes in dietary intake to reduce risk of disease.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 3: Demonstrate the ability to practice behaviors that enhance health and reduce risks.

By the end of grade five, students should be able to

- explain the relationship between food selection and oral health;
- demonstrate safe and sanitary food handling procedures that prevent disease; and
- demonstrate the ability to practice appropriate nutrition behaviors and make healthy nutritional choices.

By the end of grade eight, students should be able to

- demonstrate the ability to make age-appropriate nutritional choices based on valid information (e.g., Food Guide Pyramid, *Dietary Guidelines for Americans*) in a variety of settings;
- demonstrate the ability to make nutritive comparisons;
- demonstrate the ability to select adequate amounts of appropriate foods to meet personal health needs;
- demonstrate the ability to plan and prepare nutritionally appropriate snacks and meals; and
- demonstrate the ability to modify personal nutrition practices to avoid eating disorders.

By the end of grade twelve, students should be able to

- demonstrate the ability to utilize a personal nutrition assessment to improve nutrition behaviors;
- evaluate the selection of nutritional foods using a variety of criteria;
- evaluate alternative food selections to meet personal health needs appropriately;
- demonstrate the ability to plan and prepare nutritionally appropriate snacks and meals; and
- demonstrate how to achieve and maintain healthy body composition.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 4: Analyze the influence of personal beliefs, culture, mass media, technology, and other factors on health.

By the end of grade five, students should be able to

- relate examples of how parents, family, culture, peers, and personal preferences influence food choices;
- explain how technology influences food availability and selection;
- explain how mass media influence the selection of nutrition information, products, and services; and
- describe marketing and advertising techniques used to influence food selection and body image.

By the end of grade eight, students should be able to

- describe parent, family, peer, and environmental influences on food consumption;
- analyze factors that influence nutrition behaviors (e.g., gender, age, costs, body image);
- analyze the influence of mass media, societal messages, and technology on nutrition behaviors; and
- analyze how technology influences food availability and selection.

By the end of grade twelve, students should be able to

- analyze the influence of mass media, nutrition claims, and food advertising on personal, family, and community health;
- analyze the factors that influence nutritive content of foods (e.g., food processing and preparation); and
- analyze how technology influences food availability and selection.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 5: Use interpersonal communication skills to enhance health.

By the end of grade five, students should be able to

- demonstrate the use of effective communication skills to express nutritional needs and
- demonstrate ways to communicate consideration and respect for self and others as related to body composition and shape and dietary choices.

By the end of grade eight, students should be able to

- demonstrate the use of effective communication skills to express nutritional needs and improve nutrition in a variety of settings and
- demonstrate ways to communicate consideration and respect for self and others as related to body composition and shape, weight control, and dietary choices.

By the end of grade twelve, students should be able to

- demonstrate the use of effective communication skills to express nutritional needs and improve nutrition in a variety of settings.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 6: Use goal-setting and decision-making skills to enhance health.

By the end of grade five, students should be able to

- demonstrate the ability to apply a decision-making process to nutrition issues and problems;
- predict risks and consequences of positive and negative nutrition decisions; and
- set a personal dietary goal and track progress toward its achievement.

By the end of grade eight, students should be able to

- demonstrate the ability to use nutritional assessment to develop a personal nutrition plan and
- analyze personal nutrition practices as related to eating disorders and to the prevention of chronic disease.

By the end of grade twelve, students should be able to

- predict personal nutrition practices based on changing energy expenditures and
- develop and implement a personal nutrition plan and track progress.

Content Area II: Nutritional Choices

Content Area II: Nutritional Choices

Standard 7: Demonstrate the ability to advocate for personal, family, and community health.

By the end of grade five, students should be able to

- demonstrate ways to influence and support others in making positive nutritional choices and
- define nutrition issues that affect health in the school and community.

By the end of grade eight, students should be able to

- demonstrate the ability to promote an environment that supports appropriate nutritional choices and
- participate in school and community activities that promote positive approaches to nutritional choices.

By the end of grade twelve, students should be able to

- evaluate an advocacy plan for ensuring greater accessibility to healthful food choices in a variety of settings;
- mobilize school and/or community to advocate for community nutrition issues; and
- participate in the public policy process related to nutrition.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 1: Comprehend health promotion and disease prevention concepts.

By the end of grade five, students should be able to

- identify effective verbal and nonverbal communication skills;
- describe the characteristics needed to be a responsible friend and family member;
- identify strategies for managing stress and emotions;
- describe characteristics and behaviors that promote positive mental health; and
- recognize individual and cultural differences.

By the end of grade eight, students should be able to

- describe the interrelationships among mental, emotional, social, and physical health during adolescence;
- recognize the symptoms of depression and other mental illnesses;
- describe characteristics of mentally healthy adolescents; and
- explain relationships between mental illness and substance abuse.

By the end of grade twelve, students should be able to

- describe brain physiology and its relation to mental health and emotional control;
- evaluate coping strategies to address stress and conflict;
- evaluate healthy and unhealthy relationships and recommend solutions; and
- identify symptoms and behaviors characteristic of depression, suicide, and other mental health problems common to adolescents.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 2: Access valid health information, products, and services.

By the end of grade five, students should be able to

- demonstrate the ability to locate home, school, and community mental health and emergency services and
- identify indicators of need for valid information, support, and assistance.

By the end of grade eight, students should be able to

- explain criteria for valid mental health information from a variety of sources and
- demonstrate the ability to locate appropriate services for mental health issues.

By the end of grade twelve, students should be able to

- evaluate the validity of mental health information from a variety of sources, including the Internet and
- identify and match emotional and social health needs to community resources and services.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 3: Demonstrate the ability to practice behaviors that enhance health and reduce risks.

By the end of grade five, students should be able to

- demonstrate use of positive self-management skills (i.e., ways to manage frustration and emotions, such as fear, anger, sadness, disappointment, happiness);
- demonstrate strategies to resist negative peer pressure; and
- demonstrate positive strategies to reduce stress and anger in relation to identified stressors.

By the end of grade eight, students should be able to

- demonstrate the ability to avoid situations that are potentially harmful;
- demonstrate healthful strategies to assess and manage conflict and stress; and
- use positive strategies to express and manage strong emotions, such as anger, frustration, fear, and joy.

By the end of grade twelve, students should be able to

- develop strategies for maintaining positive self-concept throughout life;
- demonstrate the ability to assess and adjust behavior to respond appropriately to stress, anger, and other strong emotions; and
- develop and implement a personal stress management plan.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 4: Analyze the influence of personal beliefs, culture, mass media, technology, and other factors on health.

By the end of grade five, students should be able to

- compare and contrast different types of family, social, and community relationships;
- recognize influences of mass media and culture on self-perception, feelings, and relationships; and
- recognize how qualities of good character enhance emotional and social health.

By the end of grade eight, students should be able to

- analyze influences of culture and mass media on self-image, feelings, behaviors, and relationships;
- explain how information from and perceptions of peers influence mental and emotional health; and
- compare and contrast how character qualities influence emotional and social health.

By the end of grade twelve, students should be able to

- analyze how individual and family beliefs influence feelings, health behavior, relationships, and character development;
- critique and evaluate mass media messages that may influence self-image, behaviors, relationships, and character development; and
- analyze causes of conflict among youth in schools and communities.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 5: Use interpersonal communication skills to enhance health.

By the end of grade five, students should be able to

- demonstrate effective communication skills to build and maintain healthy relationships with parents, family, friends, and other adults;
- demonstrate ways to communicate care, consideration, and respect for self, for parents and family, and for the diversity of others;
- demonstrate nonviolent strategies to resolve conflicts; and
- demonstrate appropriate ways to express emotion.

By the end of grade eight, students should be able to

- demonstrate ways to communicate care, consideration, and respect for self, for parents and family, and for the diversity of others;
- demonstrate effective interpersonal communication skills; and
- demonstrate strategies for the expression of needs, wants, and feelings.

By the end of grade twelve, students should be able to

- demonstrate ways to communicate care, consideration, and respect for self, for parents and family, and for the diversity of others;
- demonstrate the effective use of communication skills in pressure situations; and
- demonstrate strategies for the healthy expression of needs, wants, and feelings.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 6: Use goal-setting and decision-making skills to enhance health.

By the end of grade five, students should be able to

- use an age-appropriate decision-making model for emotional and social health decisions;
- assess personal strengths and weaknesses in promoting and maintaining healthful relationships; and
- identify when help is needed in making decisions and setting goals.

By the end of grade eight, students should be able to

- use an age-appropriate decision-making process with positive mental health issues and problems, both individually and collaboratively;
- analyze how individual, family, and community values influence health-related decisions; and
- demonstrate the ability to assess one's personal strengths, needs, and health risks.

By the end of grade twelve, students should be able to

- analyze the short- and long-term consequences of risk decisions on emotional and social health;
- evaluate the effect of healthy and unhealthy relationships on one's decisions and goals;
- develop a life plan for achieving long-term health goals using the results of a self-assessment; and
- demonstrate the ability to apply a decision-making process to health issues and problems, both individually and collaboratively.

Content Area III: Mental Health

Content Area III: Mental Health

Standard 7: Demonstrate the ability to advocate for personal, family, and community health.

By the end of grade five, students should be able to

- demonstrate the ability to influence and support others in making positive mental health choices.

By the end of grade eight, students should be able to

- demonstrate the ability to influence and support others in making positive health choices;
- apply strategies for working cooperatively in support of mentally healthy individuals, families, or schools; and
- apply various methods to accurately promote information, ideas, and opinions about mental health issues.

By the end of grade twelve, students should be able to

- demonstrate the ability to influence and support others in making positive health choices;
- demonstrate the ability to advocate for mental health issues; and
- assess and adapt mental health campaign messages to the characteristics of a particular audience.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 1: Comprehend health promotion and disease prevention concepts.

By the end of grade five, students should be able to

- identify hazards to personal safety related to the environment and the type of injury;
- identify the consequences of violent or unsafe behavior;
- identify and develop safety strategies to avoid violence and injury to self or others; and
- identify steps to follow for emergencies related to the six types of injuries in home, school, and community environments, including varying weather conditions.

By the end of grade eight, students should be able to

- explain the relationship between positive health behaviors and the prevention of injury and premature death and
- describe causes and effects of violence.

By the end of grade twelve, students should be able to

- analyze laws and regulations related to health and safety;
- analyze the short- and long-term results of safe, risky, and harmful behaviors; and
- analyze the possible causes of conflict in schools, families, and communities.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 2: Access valid health information, products, and services.

By the end of grade five, students should be able to

- demonstrate the ability to locate community resources and services that contribute to a safe and healthy environment and
- describe and participate in school emergency procedures.

By the end of grade eight, students should be able to

- demonstrate the ability to utilize resources at home and in the school and community that provide valid safety information and services, and
- describe and participate in school emergency procedures.

By the end of grade twelve, students should be able to

- develop strategies for improving the availability of health and safety resources and services for the community;
- identify available agencies that are helpful in dealing with violent and abusive behavior; and
- analyze community emergency procedures.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 3: Demonstrate the ability to practice behaviors that enhance health and reduce risks.

By the end of grade five, students should be able to

- demonstrate strategies for reducing or avoiding unsafe situations;
- demonstrate appropriate responses to emergency situations, including first-aid procedures; and
- identify potentially hazardous household products.

By the end of grade eight, students should be able to

- develop injury prevention, management, and treatment strategies for personal and family health;
- demonstrate ways to avoid and reduce threatening situations; and
- demonstrate appropriate use of hazardous products.

By the end of grade twelve, students should be able to

- develop injury prevention and management strategies for personal, family, and community health;
- demonstrate ways to avoid and reduce threatening situations to prevent or minimize violence; and
- demonstrate emergency care procedures that may be used in life-threatening situations.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 4: Analyze the influence of personal beliefs, technology, and other factors on health.

By the end of grade five, students should be able to

- identify violent and risk behaviors and situations in mass media samples;
- describe mass media influences on behaviors associated with risk-taking and violence;
- recognize peer influences on strategies for dealing with conflict and safety; and
- describe how family and friends influence personal safety practices.

By the end of grade eight, students should be able to

- identify the effects of culture and mass media on personal safety and violent behaviors, and
- explain the effect of peers and mass media on pedestrian and vehicular safety.

By the end of grade twelve, students should be able to

- analyze influences of culture and mass media on violent and personal safety behavior;
- explain reasons for laws related to safety in the workplace; and
- assess the effects of violence on school, community, and state.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 5: Use interpersonal communication skills to enhance health.

By the end of grade five, students should be able to

- demonstrate refusal skills to enhance health and reduce exposure to risks;
- demonstrate the use of negotiation skills to promote personal safety; and
- demonstrate nonviolent strategies to resolve conflicts.

By the end of grade eight, students should be able to

- demonstrate strategies to manage conflict in healthy ways and
- demonstrate refusal and negotiation skills to reduce the risk of injury and promote personal safety.

By the end of grade twelve, students should be able to

- demonstrate communication skills necessary to prevent or reduce risk of injury;
- demonstrate refusal, negotiation, and collaboration skills to avoid potentially harmful situations;
- demonstrate strategies for solving interpersonal conflicts without harming self or others; and
- demonstrate strategies used to prevent conflict.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 6: Use goal-setting and decision-making skills to enhance health.

By the end of grade five, students should be able to

- predict consequences of unsafe behaviors;
- demonstrate the ability to apply an age-appropriate decision-making process to reduce risk of harm to self and others; and
- explain when to ask for assistance in making decisions related to safety of self and others.

By the end of grade eight, students should be able to

- demonstrate the ability to apply an age-appropriate decision-making process to situations regarding personal safety and risk.

By the end of grade twelve, students should be able to

- evaluate various strategies to manage and mediate interpersonal conflicts and
- develop and implement a plan for increasing personal safety at home, work, or school.

Content Area IV: Preventing Injuries

Content Area IV: Preventing Injuries

Standard 7: Demonstrate the ability to advocate for personal, family, and community health.

By the end of grade five, students should be able to

- demonstrate strategies to influence and support others in practicing behaviors for safe living and
- promote positive conflict resolution with peers and family.

By the end of grade eight, students should be able to

- demonstrate the ability to influence and support others in making choices that reduce the risks of intentional and unintentional injury.

By the end of grade twelve, students should be able to

- develop and implement and plan for a campaign to influence and support others in making choices that reduce the risks of intentional or unintentional injury.

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 1: Comprehend health promotion and disease prevention concepts.

By the end of grade five, students should be able to

- define *family* and identify various family structures;
- identify the stages of growth that occur during the life cycle;
- describe the influences of the family on personal health and disease prevention;
- identify responsibilities of family members to each other; and
- identify abstinence from sexual activity as the expected and healthiest behavior for school-aged children.*

By the end of grade eight, students should be able to

- analyze how family roles, rules, and responsibilities change over time;
- describe psychological, physical, and emotional changes that occur with puberty;
- compare and contrast the structures and functions of the male and female reproductive systems;
- justify abstinence as the most effective means of teen pregnancy prevention and protection of reproductive health; and
- describe strategies for the prevention of sexually transmitted diseases (STDs), Acquired Immune Deficiency Syndrome (HIV/AIDS), and unintended pregnancy.

By the end of grade twelve, students should be able to

- describe the relationship between abstinence and the prevention of health and family-related problems;
- explain the stages of pregnancy, the birth process and infant care, and the effects of the mother's health behaviors on the developing fetus and child;
- analyze prevention, symptoms, and treatment of STDs (including HIV/AIDS); and
- analyze the risks, benefits, and effectiveness of the methods of pregnancy prevention.

* Reproductive health instruction is not required below grade six but is permitted at the option of local school districts. This standard for kindergarten through grade five is appropriate if districts choose that option. It is recommended that this standard be addressed in grade five. See also the provisions of the Comprehensive Health Education Act [S.C. Code Ann. §59-32-10, et seq. (1990)].

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 2: Access valid health information, products, and services.

By the end of grade five, students should be able to

- identify and access valid information and services that promote healthy family living, and
- identify school and community resources that can help families with health and social problems.

By the end of grade eight, students should be able to

- demonstrate the ability to locate and utilize community resources that support health and social needs of families;
- demonstrate the ability to access appropriate resources for child abuse, sexual assault, and domestic violence; and
- demonstrate the ability to access valid information concerning sexuality.

By the end of grade twelve, students should be able to

- analyze validity of information about the characteristics and responsibilities of relationships (e.g., dating, marriage);
- evaluate the availability and appropriate use of information and community resources that help families with health and parenting problems; and
- demonstrate the ability to access information and services appropriate to protecting reproductive health.

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 3: Demonstrate the ability to practice behaviors that enhance health and reduce risks.

By the end of grade five, students should be able to

- demonstrate the ability to use self-management skills in family relationships;
- apply appropriate strategies that contribute a healthy family;
- demonstrate coping strategies for dealing with change within the family (e.g., birth, death, divorce, illness); and
- explain when and where to ask for assistance in harmful or abusive situations.

By the end of grade eight, students should be able to

- distinguish between safe and risky or harmful behaviors in relationships;
- demonstrate strategies to improve or maintain family health;
- demonstrate coping strategies to address changes during adolescence; and
- demonstrate skills for avoiding risky sexual behaviors.

By the end of grade twelve, students should be able to

- analyze strategies for avoiding situations that increase the risk of sexual assault or abuse;
- demonstrate coping strategies that address changes during the life cycle;
- develop strategies to improve or maintain personal, family, and community health; and
- demonstrate skills for avoiding risky sexual behaviors.

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 4: Analyze the influence of personal beliefs, culture, mass media, technology, and other factors on health.

By the end of grade five, students should be able to

- identify how the culture influences family beliefs, roles, and relationships in regard to health and
- identify how mass media and technology influence decision-making that affects personal and family health.

By the end of grade eight, students should be able to

- compare and contrast the effect of culture, mass media, and technology on personal and family health and
- analyze the influence of peers, mass media, and culture on sexual attitudes and behaviors.

By the end of grade twelve, students should be able to

- analyze factors that influence reproductive, fetal, and infant health;
- evaluate the effects of mass media, technology, and other factors on sexual attitudes and behavior;
- evaluate the impact of HIV/AIDS and other STDs on individuals and families; and
- identify South Carolina laws relating to family health, parent responsibilities, and criminal sexual behavior.

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 5: Use interpersonal communication skills to enhance health.

By the end of grade five students should be able to

- recognize verbal and nonverbal communication skills from examples and
- demonstrate the ability to use positive communication skills with parents, family members, and peers.

By the end of grade eight, students should be able to

- demonstrate the ability to utilize effective verbal and nonverbal communication skills to enhance parent, family, and peer relationships;
- demonstrate refusal and negotiation skills to protect sexual health; and
- demonstrate the ability to communicate with parents, family members, or trusted adults about sexuality.

By the end of grade twelve, students should be able to

- analyze how interpersonal communication affects health and relationships;
- demonstrate skills to communicate effectively with parents, family, and peers about sexuality and other important health issues; and
- demonstrate refusal and negotiation skills to enhance health.

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 6: Use goal-setting and decision-making skills to enhance health.

By the end of grade five, students should be able to

- describe the steps of responsible decision-making with peers and within the family;
- set a goal and develop a plan for personal responsibility within the family and track its progress; and
- identify the benefits of delaying sexual activity and avoiding parenthood until marriage.*

By the end of grade eight, students should be able to

- analyze factors that influence decisions about sexual behavior;
- predict how decisions regarding sexual behavior have consequences for self and others; and
- describe risks and consequences of early sexual involvement and benefits of delaying sexual activity and avoiding parenthood until marriage.

By the end of grade twelve, students should be able to

- predict immediate and long-term impact of health decisions on the individual, family, and community;
- examine and evaluate how individuals make choices regarding dating, marriage, childbirth, and adoption;
- analyze risks and consequences of early sexual involvement and benefits of delaying sexual activity and avoiding parenthood until marriage; and
- evaluate personal decision-making and goal-setting skills.

* Reproductive health instruction is not required below grade six but is permitted at the option of local school districts. This standard for kindergarten through grade five is appropriate if districts choose that option. It is recommended that this standard be addressed in grade five. See also the provisions of the Comprehensive Health Education Act [S.C. Code Ann. §59-32-10, et seq. (1990)].

Content Area V: Family Living and Healthy Sexuality

Content Area V: Family Living and Healthy Sexuality

Standard 7: Demonstrate the ability to advocate for personal, family, and community health.

By the end of grade five, students should be able to

- demonstrate ways to influence and support others in promoting personal and community family health.

By the end of grade eight, students should be able to

- demonstrate the ability to influence and support others in making choices that promote healthy families and healthy sexual development.

By the end of grade twelve, students should be able to

- compare and contrast strategies for promoting individual, family, and community health;
- provide volunteer service to family community health initiatives; and
- advocate for adolescent, family, and community health.

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Standard 1: Comprehend health promotion and disease prevention concepts.

By the end of grade five, students should be able to

- distinguish drugs and medications as potentially harmful or helpful;
- identify short- and long-term effects and common health problems resulting from use of ATOD;
- identify the influences of family, peers, mass media, school, community, and laws as related to the use of ATOD; and
- describe the impact of ATOD use/abuse on the individual, on family health, and on society.

By the end of grade eight, students should be able to

- describe the relationship between ATOD use and physical injury, violence, disease, and premature death;
- describe risks associated with ATOD use, dependence, and addiction; and
- describe the impact of ATOD use/abuse on the individual, family, and society.

By the end of grade twelve, students should be able to

- evaluate the long- and short-term effects of ATOD use on health, behavior, appearance, and the ability to contribute to society;
- analyze the cycle of addiction as it relates to individuals and families; and
- describe the impact of ATOD use/abuse on the individual, family, and society.

Content Area VI: Alcohol, Tobacco, and Other Drugs

Content Area VI: Alcohol, Tobacco and Other Drugs (ATOD)

Standard 2: Access valid health information, products, and services.

By the end of grade five, students should be able to

- demonstrate the ability to locate valid information concerning ATOD use and
- demonstrate the ability to access information on proper use of over-the-counter and prescription medications.

By the end of grade eight, students should be able to

- demonstrate the ability to utilize resources for ATOD-related problems and
- access valid information on ATOD issues.

By the end of grade twelve, students should be able to

- demonstrate the ability to access resources for assistance with ATOD problems;
- demonstrate ability to access positive ATOD prevention activities; and
- evaluate information sources related to ATOD.

Content Area VI: Alcohol, Tobacco, and Other Drugs

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Standard 3: Demonstrate the ability to practice behaviors that enhance health and reduce risks.

By the end of grade five, students should be able to

- demonstrate age-appropriate ability to reduce the risks of ATOD use;
- demonstrate the ability to use medications appropriately; and
- explain when to ask for assistance in dealing with ATOD abuse in the family.

By the end of grade eight, students should be able to

- demonstrate the ability to use medications properly;
- demonstrate the ability to avoid potentially harmful situations related to ATOD use;
- demonstrate individual responsibility for preventing risky ATOD behaviors; and
- assess personal risks related to ATOD use.

By the end of grade twelve, students should be able to

- analyze personal risks related to ATOD use, misuse, and addiction;
- demonstrate strategies to avoid and reduce the risks in ATOD use; and
- demonstrate the ability to use stress management strategies.

Content Area VI: Alcohol, Tobacco, and Other Drugs

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Standard 4: Analyze the influence of personal beliefs, culture, mass media, technology, and other factors on health.

By the end of grade five, students should be able to

- recognize the influences of culture and mass media on behaviors related to ATOD use and
- recognize the influences of peers and family on behaviors related to ATOD use.

By the end of grade eight, students should be able to

- analyze the effect of mass media, culture, gender, age, and other factors on attitudes and behaviors related to ATOD use;
- analyze advertising messages related to alcohol and tobacco; and
- recognize current policies, laws, and criminal consequences related to ATOD use.

By the end of grade twelve, students should be able to

- assess influences of individual, family, culture, and peer pressures on ATOD use;
- evaluate ATOD mass media messages and marketing techniques; and
- evaluate current policies, laws, and criminal consequences related to ATOD use.

Content Area VI: Alcohol, Tobacco, and Other Drugs

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Standard 5: Use interpersonal communication skills to enhance health.

By the end of grade five, students should be able to

- demonstrate effective verbal and nonverbal communication skills to make positive choices concerning ATOD and
- demonstrate strategies and skills to refuse alcohol, tobacco, and other illegal drug use.

By the end of grade eight, students should be able to

- demonstrate resistance and negotiation skills to avoid ATOD use and
- demonstrate healthy ways to express feelings and relieve stress.

By the end of grade twelve, students should be able to

- demonstrate resistance and negotiation skills to avoid ATOD use and reduce risk situations.

Content Area VI: Alcohol, Tobacco, and Other Drugs

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Standard 6: Use goal-setting and decision-making skills to enhance health.

By the end of grade five, students should be able to

- predict the impact of ATOD use;
- demonstrate the ability to apply a decision-making process to issues dealing with ATOD use; and
- use goal setting as a deterrent to ATOD use.

By the end of grade eight, students should be able to

- apply decision-making strategies to ATOD issues and
- predict how decisions regarding ATOD use have consequences for individuals, family, and society.

By the end of grade twelve, students should be able to

- predict legal, financial, occupational, and family problems associated with ATOD use;
- apply decision-making strategies to ATOD issues;
- develop a lifelong health plan that addresses use and nonuse of ATOD, including medications; and
- evaluate the impact of ATOD use on one's life plan.

Content Area VI: Alcohol, Tobacco, and Other Drugs

Content Area VI: Alcohol, Tobacco, and Other Drugs (ATOD)

Standard 7: Demonstrate the ability to advocate for personal, family, and community health.

By the end of grade five, students should be able to

- demonstrate strategies to influence and support others in making positive choices concerning ATOD and
- demonstrate the ability to work cooperatively with others in the prevention of illegal ATOD use.

By the end of grade eight, students should be able to

- demonstrate the ability to work cooperatively to prevent ATOD use among adolescents;
- demonstrate the ability to influence and support others in making positive choices regarding the use of ATOD; and
- support school and community efforts regarding the illegal use of ATOD.

By the end of grade twelve, students should be able to

- advocate for ATOD policies, laws, and programs that promote a safe and healthy society;
- support school and community efforts regarding the illegal use of ATOD; and
- demonstrate the ability to work cooperatively with others in preventing misuse of ATOD.

CHAPTER FOUR

ASSESSMENT

The Purposes of Assessment

In many ways, assessment is the driving force behind education in that it provides the basis for accountability. Assessment is important because it affects the way students view themselves; the way parents, community, and governing bodies evaluate schools and districts; and the way the citizens of this nation compete with those of other nations in a worldwide marketplace. The variety of consequences suggests why the nature of particular assessments will differ according to the purpose of the evaluation.

Educational assessment is the collection of information used to evaluate a student or a system (class, school, district, or curriculum/program). All assessment in health and safety should focus on students' attainment of health literacy, which includes the knowledge of health-related information as well as the application of that knowledge to

- critical thinking and problem solving;
- responsible, productive citizenship;
- self-directed learning; and
- effective communication.

In addition to measuring student progress toward health literacy, health assessment should inform the family, school, and community and enable educators to focus programmatic efforts on the development of health literacy and to monitor the effectiveness of health and safety programs. In general, health assessment should

- be consistent with the unifying ideas of this framework;
- focus on applying knowledge and skills to achieve health literacy;
- provide useful feedback to individual students, teachers, and parents;
- provide baseline health literacy data so that the behavioral changes of groups can be tracked over time and the programs can be evaluated and refined;
- measure the extent to which the coordinated school health system enhances and reinforces health literacy; and
- promote ongoing refinement of both health education and the entire coordinated school health system.

However, as suggested above, measurement of health literacy may differ according to the various purposes of the assessment and the level or size of the group assessed. For example, while individual student assessment will be based on classroom performance, assessments of groups/systems (classes, schools, districts, and curricula/programs) may involve indicators that sometimes measure health literacy in other ways. The different purposes and types of assessment are addressed in the following sections of this chapter.

Student Assessment

Student assessment is the collection of information used to evaluate student learning. Its purpose is to evaluate student progress and provide meaningful feedback to students, teachers, and schools so that instruction can be improved. The evidence of learning we use and our methods for measuring that learning must accurately reflect what students need to know (content) and be able to do (skills).

Knowledge of essential facts and concepts is necessary in every subject area. Also, the application of health-related knowledge and skills in real-life situations is critical because it is tantamount to survival for some students. Both knowledge and application need to be assessed.

Principles of Student Assessment

The following principles should be integrated into the design and selection of all student assessment in health and safety. The assessments should

- measure student achievement in a variety of ways (projects, tests, tasks, portfolios, open-ended questions, etc.);
- examine the extent to which all students are achieving the four underlying ideas of health literacy (critical thinking and problem-solving skills; responsible, productive citizenship; self-directed learning; and effective communication);
- focus on health and safety knowledge and skills that increase positive and reduce negative health behaviors;
- be ongoing and integrated as part of the learning process;
- provide meaningful feedback (for individual students and improvement of instruction);
- include performance measurement related to real-life situations; and
- accommodate the developmental stages of students.

Types of Student Assessment

In order to measure the knowledge of facts and concepts as well as the students' skill in applying this knowledge, classroom assessments should include both objective and performance measures.

Objective Assessment

Objective tests written by the teachers themselves (multiple-choice, true-false, fill-in-the-blank, matching, etc.) are efficient and easy means of measuring the knowledge of facts and concepts when there is a single correct answer. Professionally developed objective

tests can measure higher levels of learning (i.e., application, analysis, synthesis, and evaluation); however, most tests given in classrooms do not.

Objective classroom tests typically cannot measure whether or not students are able to solve a problem by analyzing, organizing, and presenting data, nor do they require that students demonstrate the processes used to obtain an answer. Objective tests do give a quick picture of what students know.

Performance Assessment

In order to fully measure what students know and are able to demonstrate, classroom evaluation should also include performance assessment. Performance assessments are especially well suited to certain content areas since they allow teachers to directly observe the application of the desired skill. Measurement of the application of knowledge and skills completes the partial picture provided by classroom objective tests. Some assessments are described as being more authentic than others because they more fully, fairly, and equitably reflect what students know and can do in real-life situations. Performance assessments usually fit this description more closely than objective tests because they require students to organize and present their knowledge and skills in ways that more closely resemble real-world applications.

Here are some examples of activities that can be used in performance assessment:

- Journals and learning logs provide insight into reading and writing development.
- Group participation allows students to share, discuss, and analyze various ideas and concepts while solving problems or completing projects.
- Debates encourage students to share the pros and cons of issues and to develop language and reasoning skills.
- Role-playing, improvisations, and reenactments enable students to explore their understanding of various experiences.
- Video and audio productions allow students opportunities to demonstrate their visual or artistic talents through presentations in the form of songs, theatrical productions, poems, plays, short stories, and so forth.
- Portfolios foster students' ability to evaluate their own work and allows them to demonstrate that they can create a purposeful collection of student work gathered across grading periods.
- Peer critiques or interviews and conferences offer ideal ways to get to know students and determine their levels of understanding.
- Self-appraisal includes risk assessment and personal inventory to give students an understanding of their health status.

Selection of Assessments

While the purpose of the assessment is always a major factor guiding the selection and design of particular assessment tools, other conditions are also important. For example, assessment decisions should consider

- staff competence and general level of experience,
- previous staff development in assessment,
- the availability of resources (e.g., personnel, time, funds),
- the nature of the objectives being assessed,
- the needs of the assessment audience, and
- the way the assessments are to be used (e.g., to grade students, to change curriculum).

The strategies that are being used should be those that are most appropriate to the total assessment context.

The selection, design, and use of assessment techniques should also be guided by considerations of validity, reliability, and objectivity (i.e., the extent to which strategies will yield information that is relevant, accurate, and verifiable). To help ensure that student assessments have these three characteristics, the following guidelines may prove helpful.

- Judgments should be based on the results of multiple assessment techniques; a variety of formats and methods of assessment should be used.
- Assessment procedures should be fair to all students.
- Assessments should adequately represent the range of objectives and standards that students are expected to achieve.
- The techniques used for assessment should be compatible with the approaches used for instruction.
- The criteria for making judgments about student responses should be clearly established.

It is essential for health and safety educators and their students to be active participants in the assessment process. In fact, assessment itself might best be viewed as a learning experience—one that encourages teachers and students to reflect on their classroom experiences and to share those reflections with family, school, and community. With that perspective, it becomes apparent that much of what goes on in classrooms every day involves assessment. Throughout a given class period, the teacher and students continually evaluate their own work and the work of others. The challenge for health and safety educators is to find innovative ways that provide systematic feedback about students and programs.

System Assessment

Definition and Components

Assessment of comprehensive health and safety education provides valuable information for planning program improvements to promote student health literacy. The system assessment should involve monitoring and evaluating the impact of the program on students, family, and community. An effective system assessment will measure the following:

- the allocation of staff and resources to support comprehensive school health and safety education;
- the number of students participating in various learning activities;
- the implementation of comprehensive school health and safety instruction;
- the levels of family and community involvement;
- the use of community health data;
- the infusion of health and safety education into all curriculum areas;
- system compliance with local, state, and federal regulations; and
- the extent of learning by groups of students.

The overall program assessment should begin in the initial planning stages of the comprehensive health literacy program and continue annually. Schools and districts can monitor their efforts to promote student health and safety literacy and adjust those efforts as necessary.

Planning Classroom Assessment

The classroom is the basic level of the system assessed. While student assessments are necessary to measure the learning of individual students and are used to assign grades to students for their work, system assessments may also be needed to evaluate health literacy for the class as a whole. Obtaining valid data begins with planning and continues through selection, administration, and interpretation of the results—as shown in the following components.

Evaluating Implementation and Effects of Programs

Since health behavior is influenced by family, peers, and community as well as the school, evaluating the effectiveness of health and safety instruction and the coordinated school health system may seem difficult to do. Given the wide range of data that might be included in an assessment of comprehensive school health and safety instruction and the different individual assessment activities, evaluation is viewed in terms of three different approaches: *process*, *content*, and *impact*.

Process evaluation focuses on what is happening in the various components of a coordinated school health and safety system. It looks at how many students are participating, the extent to which all the components of a coordinated system are being implemented, the level of parent and community involvement, the degree to which appropriate program planning has taken place, the extent of linkages among the components of a coordinated system, and other factors. It offers a picture of the process of program planning and implementation.

Content evaluation measures how well the actual content of instruction matches the standards in this framework. This match is often referred to as content validity because it measures whether or not the intended instruction actually takes place. Content validity is essential to ensure consistency and quality in health education programs.

Impact evaluation measures the extent to which the goals of the program have been accomplished. While student assessments should focus on whether or not students have acquired essential knowledge and skills related to health and safety, health educators also want to know if their instruction has actually affected students' health-related behaviors. Are students choosing more nutritious foods? Are they choosing not to drink when they drive? The collection of such data may call for the use of system assessments that use group rather than individual assessments.

The Use of Group and Individual Data

As in all educational disciplines, individual student assessment data are used in health education to evaluate student progress and to provide feedback about instruction to the individual students and parents as well as teachers. Aggregation of these data across classes, schools, districts, or even states is done in some subject areas, including health, to evaluate the learning of groups of students. In most subjects, little of this information is controversial; therefore, collection of the data for individual students (by name) presents few problems for educators.

However, as noted above, assessment of health literacy does not require measurement of the impact of instruction on actual health behaviors of students. That kind of information is such that might be distorted if collected (and graded) for individual students (who would likely respond with socially desirable or teacher-liked answers). For example, distortion of data might occur with a test question in driver safety about how often the student wears seat belts. A student might answer yes, whether he or she really wears them or not, because a grade is at stake. Some information might also be considered overly intrusive or a violation of privacy by some parents or the students themselves. An example of the intrusion/privacy problem might be a test question about personal beliefs or behaviors. Neither the student nor the parent might wish to reveal such information. And such assessment would be an inappropriate measure of the health literacy objective.

Both kinds of problems can result in invalid data about health behaviors. Moreover, health educators sometimes want to assess long-term impact of instruction. Has the number of teen pregnancies gone down in the district since the curriculum began? Are students actually staying away from illegal drugs? All of these behavioral questions call for the use of other kinds of evaluation measures—for example, the anonymous group surveys or the use of statistical data from health departments, courts, or other social agencies.

Therefore, the recommendations of this document follow the earlier admonition in this chapter regarding the validating of data: Use the type of assessment appropriate for the purpose of the assessment. Classroom tests (tests, performance tasks, projects, etc.)

should not be used to evaluate individual student behaviors, beliefs, or attitudes. To assess change in health-related behaviors (and/or associated beliefs or attitudes), system measures such as anonymous group surveys and/or information from public agencies are recommended.

Recommendations

Several general recommendations for assessment in health and safety have been provided in this chapter:

- The type of assessment used should fit the purpose of the assessment.
- Individual classroom assessments should measure both the students' knowledge of essential facts and concepts and their ability to apply the knowledge and skills.
- Both objective and performance assessments should be used in the classroom.
- The impact of instruction on health-related behavior should be measured through system assessments, not through individual classroom assessments.

One final recommendation is offered for future assessment of health and safety. To measure quality and efficacy, assessments of health and safety programs need to be conducted statewide. The most economical suggestion for implementing such an evaluation is a system assessment (that may include student assessments) in which samples of programs across South Carolina would be evaluated every three years. If this plan and the performance indicators in this document are utilized, all programs could expect to be evaluated by the same standards every three years, and valid and relevant data would be obtained.

Assessment Examples

The following set of exercises is adapted from the Health Education Project module, *Tobacco Use Prevention*, produced by the State Collaborative on Assessment and Student Standards (SCASS) and published in 1995 by the Council of Chief State Schools Officers (CCSSO) in Washington, DC. South Carolina is a continuing participant in this project.

Performance tasks are exercises, or curriculum-embedded projects, that students complete over an extended period of time (i.e., more than one class period). The exercise involves several parts and may require multiple activities and types of responses. Students may complete some work in groups, but the final product always includes one or more individually completed components. Although performance tasks will require health facts and concepts specific to the context of the assessment, they are intended to assess thinking and behavioral skills, such as accessing information, analyzing influences, making decisions, or communicating. Task activities could include community or library research, brainstorming and other group work, report or journal writing, role-playing or other demonstrations, and the use of art or instructional media such as posters, brochures, or videos. Performance tasks are intended to be grounded in authentic student experiences and in investigations and interactions that are genuine for students in their home, school, or community environments.

Example Performance Task: A Smoking Body

Health Standards Assessed: VI.1, VI.2, and VI.4

Other Standards Reinforced: VI.5, Language Arts, Science

Grade Level: Middle School

Overview

In this activity, students will write and perform a skit in which they play parts of the body that tobacco affects. This activity is an opportunity for students to synthesize what they have learned about the physical effects of tobacco. By working together to access information to prepare, students reinforce their interpersonal communication skills. The exercise also provides students with the opportunity to apply the knowledge they have gained in an enjoyable and instructive way.

Requirements

Organize students into small groups of four to five students. Each group will write and perform a skit that portrays some of the effects of tobacco on the human body. Each skit must include the effects of using tobacco products on the brain, the heart, and the

lungs. The skit must also include the effects on other organs or body parts (e.g., liver, kidneys, throat, mouth) chosen by the group. In addition, each student will write a short descriptive paper that summarizes the group's skit and identifies the differences between his or her group's skit and those performed by other groups.

Time

Students will need at least one class period to write the skit; additional time should be provided to research the effects of tobacco. Each skit should be three to five minutes long and may be presented over two days.

Materials

Students should have access to text, library, or other written or media materials about the effects of tobacco on the body. Students will need writing and art materials: tag board, construction paper, markers, and so forth. Other creative skit materials may be provided.

Instructional Review

Students should be able to identify the effects of tobacco on different parts of the body. Students will need more information than just the general knowledge of the effects of smoking. They will need to be able to recall tobacco's effects on specific organs of the body and to access sources of tobacco effects information.

Assessment Criteria

An acceptable student performance on this task would include a written script and the complete performance of three- to five-minute skit that reports on the harmful effects of tobacco use on various parts of the body. Accurate effects on brain, heart, lungs, and at least two additional organs should be presented. Higher rating should be given for inclusion of multiple or detailed effects and additional organs. An acceptable student paper includes at least two paragraphs, one accurately describing the focus of the skit and the second identifying differences in skits performed by other groups.

SHORT-ANSWER RESPONSE. An exercise in which a student provides a word, a phrase, a couple of sentences, or a diagram in response to a question.

Example Short- Answer Response: Tobacco Information Sources

Health Standards Assessed: VI.2

Grade Level: Middle School

Name three valid sources of accurate information about the effects of tobacco use on body systems.

1. _____

2. _____

3. _____

SELECTED RESPONSE. An exercise in which the student selects one or more responses from among predetermined answers; often termed a “multiple-choice” item. A test module composed of selected-response items together with constructed-response items is intended to assess a broad range of knowledge and concepts, while performance tasks focus on assessing skills. Well-developed selected-response items generally assess comprehension and the application of knowledge and concepts.

Sample A **There has been a great deal of research about what it takes to quit smoking. Based on these research findings, which statement is correct?**

- A. It is easy to quit smoking cigarettes if you have enough will power.
- B. Nicotine causes psychological as well as physical dependency.
- C. People who start smoking at a young age have less trouble quitting than people who start smoking when they are older.
- D. Most people are successful in quitting the first time they try.

Sample B. **Which of these statements about chewing tobacco is true?**

- A. Chewing tobacco is safer than smoking tobacco.
- B. Chewing tobacco is not addictive because you don’t inhale nicotine into the lungs.
- C. Chewing tobacco increases your risk of mouth and throat cancer more than smoking tobacco.
- D. Chewing tobacco is a good substitute for people who like tobacco but don’t want the nicotine.

Sample C. **Which of these statements about nicotine is *not* true?**

- A. Nicotine is both a stimulant and a depressant.
- B. Nicotine affects all parts of the central nervous system.
- C. Nicotine is the chemical in tobacco that causes lung cancer.
- D. Nicotine is absorbed through the lungs, the mouth, and the stomach.

CONSTRUCTED OR EXTENDED RESPONSE. An exercise in which a student provides up to several paragraphs or more of extended text or other type of written response to a question. Constructed- or extended-response items, together with selected-response items, are intended to assess a broader range of knowledge and concepts than can be addressed with a performance task. Most of the extended-response items are designed to elicit responses that range from one or two sentences to one or two paragraphs. They could also prompt the student to complete or draw a chart, graph, or schematic diagram. Good items present students with authentic contexts and prompts that require more than rote memory.

Example Extended Response: Health Effects of Tobacco Use

Health Standards Assessed: VI.1

Grade Level: Middle School

Sample A Using tobacco affects more than your physical health. What are some of the effects of tobacco on your appearance, mental attitude, and/or pocketbook?

Sample B Your favorite uncle has come to live in your house for a few weeks after moving from another state. He is starting a new job and looking for a place of his own to live. However, he smokes, and your family has a no-smoking rule inside your house. Your uncle is grumbling, and relationships are a little strained. What could your parents say to your uncle that may help him understand the family's no-smoking rule?

CHAPTER FIVE

PROFESSIONAL DEVELOPMENT

Accomplished teaching involves making difficult and principled choices, exercising careful judgment, and honoring the complex nature of the educational mission. Teachers employ technical knowledge and skill, yet they must be ever mindful of teaching's ethical dimensions. The primary mission is to foster the development of skills, dispositions, and understandings while responding thoughtfully to a wide range of human needs and conditions. Teachers owe joint allegiance to the forms and standards of knowledge within and across disciplines and to the students they serve. They must acquire and employ a repertoire of instructional methods and strategies yet remain open-minded and reflective about their practice, drawing lessons from experience. Teachers' professional responsibilities focus on instructing the students in their immediate care and participating in supporting activities within the school and in partnership with parents and the community.

Teaching is often portrayed as a conserving activity—transmitting culturally valued knowledge and skills to succeeding generations. It is that and more. Teachers also have a responsibility to question settled structures, practices, and definitions of knowledge; to invent and test new approaches; and, where necessary, to pursue change in the organizational arrangements that support instruction. As agents of the public interest in a democracy, teachers contribute to the dialogue about the kind of society they seek both to preserve and improve, and they initiate future citizens into this ongoing public discourse (National Board for Professional Teaching Standards 1994).

What Teachers Should Know and Be Able to Do

Effective health and safety education teachers possess qualities in common with teachers in any discipline. In addition to these common qualities, health and safety education teachers have the special vision for and a commitment to the idea that health and safety are important to every student's ability to succeed in life. Successful teachers have such a strong belief in their discipline that they model what they teach.

In order for health and safety education programs to succeed, they require qualified health and safety personnel. Education for health and safe living deserves acceptance as an inherent right of human beings. Since society is placing emphasis on quality of life, it should provide citizens with effective means of preserving life. Health and safety personnel are the pivotal element in accomplishing this goal.

All teachers should have the following qualities:

- A commitment to students and their learning.
 - Teachers recognize individual differences in their students and adjust their teaching accordingly.
 - Teachers understand how students develop and learn.

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- Teachers treat students equitably.
 - Teachers' missions extend beyond developing the cognitive capacity of their students.
- A knowledge both of the subjects they teach and of the methodology for the delivery of those subjects to students.
- Teachers appreciate how knowledge in their subject areas is created, organized, and linked to other disciplines.
 - Teachers command specialized knowledge of how to convey a subject to students.
 - Teachers generate multiple paths to knowledge.
- The responsibility for managing and monitoring student learning.
- Teachers call on multiple methods to meet their goals.
 - Teachers orchestrate learning in group settings.
 - Teachers place a premium on active involvement.
 - Teachers regularly assess student progress.
 - Teachers are mindful of the relationship of teaching activities to objectives.
- The ability to think systematically about their practice and to learn from experience.
- Teachers are continually making difficult choices that require their judgment.
 - Teachers seek the advice of others and draw on education research and scholarship to improve their practice.
- The ability to enhance teaching through an active participation in their learning community.
- Teachers contribute to school effectiveness by collaborating with other professionals.
 - Teachers work collaboratively with parents.
 - Teachers take advantage of community resources.

Recommendations

Achievement of effective health and safety education programs is contingent upon an increase in the number and employment of qualified certified health and safety education teachers. Priority must be given to obtaining the resources to upgrade teacher preparation and certification and to assure that health is taught by qualified teachers.

The following priority actions are recommended.

- Establish health and safety as a critical teaching need.
- Require that middle and high school health and safety education be taught as separate courses by certified health education teachers.

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- Revise the criteria for teacher preparation, certification, and accreditation to include a requirement that all elementary teachers certified and employed in South Carolina have a minimum of two health and safety courses:
 1. general health and safety (content-knowledge) and
 2. methodology (implementing skills-based instruction, wellness concepts, training with effective curricula and resources).
 - Provide assessment of health and safety learning standards at the school, district, and state levels.

The following strategies for achieving these priorities are recommended.

- Develop an add-on certification program for teachers in related disciplines.
- Establish a Lead Teacher Program for health and safety specialists in elementary schools.
- Require that schools, districts, and/or the State yearly provide in-service opportunities specific to health and safety education certification.
- Accept recertification credits from professional organizations such as the American Red Cross and from agencies such as DHEC and the CDC.
- Provide alternative certification for health and safety teachers based on experience, district recommendations, and in-service completion.
- Require Human Sexuality/Family Life certification endorsement for all middle and high school teachers responsible for sexuality instruction.
- Establish a health leadership training module for principals.
- Identify and monitor current and projected personnel needs for health and safety education.
- Provide state monitoring for compliance with the requirements of the Comprehensive Health Education Act.
- Develop criteria for qualifications needed to work with special populations, to determine needs of students, and to assess achievement of standards.

Colleges and universities should address the following priority actions.

- Develop and strengthen additional teacher preparation programs in school health and safety education.
- Ensure that rigorous courses are required to meet teacher certification requirements that are consistent with the skills needed to teach the Health and Safety Education Curriculum Standards at the elementary and secondary levels.

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- Promote college, school, and agency collaboration in the development of preservice and in-service courses that include:
 - strategies and techniques for teaching health and safety education that meet learning standards,
 - add-on certification for teachers in related disciplines,
 - a wide range of experiences working actively with students within a school setting,
 - encouragement to participate in health and safety education professional organizations and meetings, and
 - opportunities to achieve Certified Health Education Specialist (CHES) certification.
 - Evaluate, interpret, and disseminate research findings in health and safety education.

The State Department of Education should address the following priority actions.

- Ensure that certification and recertification requirements are consistent with the Health and Safety Education Curriculum Standards and these recommendations.
- Conduct school health and safety education program assessment for achievement of grade range standards at state, district, and school levels.
- Develop key indicators and conduct annual reviews of district and school compliance with provisions of the Comprehensive Health Education Act.
- Ensure that discipline-based professional development activities are designed to support teachers and schools in translating the instructional vision of the Health and Safety Education Curriculum Standards into classroom practice.

The following are additional recommended leadership strategies and activities for the Department of Education.

- Provide professional development and technical assistance to schools in their effort to meet health and safety education standards. The Department should provide at least the following needed services:
 - identify exemplary health and safety education programs,
 - offer opportunities for school personnel to observe exemplary programs in action,
 - provide teacher training in assessment strategies,
 - disseminate current research to teachers and administrators,
 - encourage schools and districts to field-test (pilot) instruction and assessment techniques, and
 - collaborate with colleges and universities.

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- Provide leadership to ensure that district strategic plans incorporate activities for health and safety staff development that make effective use of local and statewide resources and that reflect effective practice.
 - Develop a Leadership Academy training module for principals on the requirements of the Comprehensive Health Education Act and strategies for meeting health and safety education learning standards.
 - Strengthen and support existing networks to facilitate improved communication among public school and university-based teachers, preservice teachers, students, and community agencies.

SELECTING INSTRUCTIONAL MATERIALS FOR HEALTH AND SAFETY EDUCATION

The purpose of this chapter is to provide guidelines and criteria for selecting appropriate materials for health and safety instruction. These criteria should be used for review and selection of materials for statewide adoption and for the selection and adoption of instructional materials to be used in local districts and schools.

Foundation Principles for Materials Selection

Health and safety education is unique among the disciplines in that it is characterized by the rapidly and continually changing nature of its content. New health knowledge is generated at an increasing pace, and instructional materials and curricula must be sufficiently flexible to incorporate new content on a regular basis. Health information is vital to life. Credibility and believability are important criteria since life-threatening actions derive from health information. It is, therefore, critically important that health materials reflect accurate, factual, credible, and current information.

Since concepts of health have strong roots in culture, controversy, mythology, and misrepresentation are often associated with health issues. Myth, opinion, and biased information have no place in health materials unless they are clearly labeled as such. If controversial health issues are included, they should be presented with a balanced approach, clearly communicating the different views on the issue.

Unlike other subjects whose essential curriculum elements are based on traditional concepts, basic skills, politics, or even testing, the field of health and safety education is epidemiological, or disease-driven. Priorities are set on the basis of the most current and pressing health problems as determined by population-based data. Consequently, trained health educators need to be centrally involved in the materials review process. Materials must be sufficiently responsive to differences in target populations. Treatment of gender, cultural, and minority health issues should reflect balance and respect for differences.

Health is an application discipline, requiring knowledge of the physical, social, and behavioral sciences; language arts and communication skills; and higher order thinking and psychomotor skills. The interdisciplinary nature of health contributes to the feasibility of infusing health content and skills across disciplines. These characteristics necessitate that health materials be user-friendly for teachers who may not be expert and be flexible enough to interrelate and connect with other disciplines.

The field of health and safety education is comprised of a wide array of topics and professional organizations. No single piece of material can adequately address all areas. Instructional materials and curriculum units that address comprehensive health instruction as well as single-topic or thematic units and issues are appropriate.

Focus on Research-Based Materials

Health and safety often receive low-priority status in the curriculum. When preparation in health content is lacking in teaching staff, priority should be given to the selection of research-based curriculum materials that have been proven effective in accomplishing their objectives. This is preferable to attempting to invent or construct curricula when depth of preparation in the content area is not available.

Health and safety materials selection must be grounded in sound learning theory. Materials must be appropriate to meet differences in learning styles, age, and developmental learning needs of students. Teachers must utilize an array of multiple-media materials to meet the varied learning needs of students.

In addition, current research, including meta-analyses, has identified the necessary elements of health education programs that are highly effective in preventing or reducing risk-taking behaviors. Where these elements are incorporated in well-implemented instruction, credible evaluations have demonstrated that risk behaviors are delayed and protective behaviors are increased. Programs that work include the following elements:

- They are founded and grounded in sound social learning theory that reflects
 - skills for inoculation, or resistance to pressure;
 - health belief constructs leading to action: benefits, barriers, self-efficacy, and perceived success; and
 - the cognitive-behavioral prevention skills of modeling and personalization, training, and situational practice.
- They focus specifically on the behaviors to practice and those to avoid, and they provide clear, accurate factual information on risks and protection.
- They include activities that address peer, social, and mass media influences on behaviors, and they reinforce clear and appropriate norms on protective behaviors.
- They provide opportunities for modeling and practice of protection and risk-reduction skills.

Integrating Health Messages in School and Community

Since class time is finite, health and safety materials should enable interdisciplinary instruction and infusion so that instructional time can be used efficiently. Effective health and safety instruction is skills-focused, so materials should have the content, emphasis, and learning-support resources to enable skills-based instruction and support cooperative learning.

Since the effectiveness of health and safety instruction is highly influenced by reinforcement in the home, instructional materials should include activities that are appropriate for involving parents and families outside the classroom. These interactive activities might include parent-child homework and projects. They may also involve

parents in the use of community resources and in special events such as health fairs, parent-child workshops, and conferences.

Elements of Health Education Policy

Districts should have an instructional materials policy that involves classroom teachers in the review and selection process. This policy should include a process for updating materials regularly and should provide teachers with access to varied and multiple-media instructional materials without extraordinary effort. Materials and units for teaching the required sexuality topics must be reviewed by a district community advisory committee, as specified by the Comprehensive Health Education law.

Sufficient funds should be provided for the purchase of quality skills-based instructional materials. Yet, since quality supplemental materials are almost always the most costly, the resource of time to search and discover free and inexpensive materials should also be available.

Criteria for Materials Selection

Instructional materials for health and safety should comply with the provisions of the Comprehensive Health Education Act of 1988. Additionally, so that the best quality resources are selected with regard to content, methodology, instructional support, and aesthetic/technical quality, these materials should meet the criteria that are set forth in the following statements.

As the selection for instructional materials is made, it is imperative that the **content** of the materials demonstrates the following:

- adequacy and depth of content coverage;
- balanced coverage of relevant topics;
- accurate, factual, current, credible health and medical information;
- balanced presentation of controversial issues;
- inclusion of higher-order thinking processes;
- promotion of health skills as well as knowledge;
- emphasis on priority health risks/behaviors; and
- organization that reflects current health education theory and principles.

It is imperative that the **methodology** reflect the following:

- provision for varied learning levels, readability;
- provision for variety of learning styles;
- provision for variety in appropriate teaching strategies;
- provision for student assessment strategies and resources that are both varied and relevant;
- balanced and respectful treatment with regard to gender, culture, and minority status;
- research-based prevention principles and skills-based instructional approaches;
- interdisciplinary feasibility with clear points of interrelationships and interconnections;

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- clear provisions, strategies, and activities for integration across disciplines;
 - capacity to be user-friendly for out-of-field teachers; and
 - adapted activities appropriate for special needs students.

Instructional support should include the following:

- material whose design reflects sound health and safety education research or theoretical base;
- material that is proven effective in practice based on research data that are credible, found in referred journals, or available for review;
- high quality teacher guidance materials; and
- high quality resource and supplemental materials.

There should also be an **aesthetic or technical quality** that reflects the following:

- visual appeal,
- production quality, and
- current language/dress/hairstyles.

Types of Appropriate Instructional Materials

The following lists are an assortment of various types of instructional materials available to teachers in the field of health and safety education.

Print Materials

- books, reference books, textbooks, booklets;
- periodicals, magazines, journals, newspapers;
- data and technical reports, copies of laws;
- brochures, pamphlets, leaflets, flyers, transparencies;
- packaged curriculum units, teacher guides and lessons; and
- resource kits and instructional planning materials.

Technology

- films, filmstrips, videos, ITV programs, satellite broadcasts, audiotapes, laser video disks, interactive videos, DVD videos;
- computer software, and interactive programs, CD-ROMs; and
- computer networking, Internet sites, communications technology.

Dimensional Materials

- models, exhibits, simulation kits, manipulatives and materials for health experiments and demonstrations;
- learning centers, visual and interactive displays; and
- health promotional materials such as posters, buttons, and stickers.

Sources of Instructional Materials

Listed below are a few of the places where teachers in the field of health and safety education can locate appropriate instructional materials:

- commercial and nonprofit publishers;
- national, state, and community health and public safety agencies;
- government health and public safety agencies;
- national and state health and safety professional associations;
- voluntary, private, nonprofit health and safety organizations;
- college/university health and safety education departments; and
- health and safety professional journals.

Health and safety education is unique among school-based programs in that there is a significant body of research regarding the program elements, curricula, and instructional materials that are effective in helping children and youth to learn positive healthy behaviors. Schools having the vision to incorporate sound research-based elements in designing their health education programs will have a better chance in assuring that all their students learn the skills necessary to protect their health.

CONCLUSION

School health and safety education is not new. It has been part of the mission of public education since the beginning of public schools. Health was one of the seven cardinal principles of public education. Unfortunately, it has not been systematically implemented and supported at a level necessary to make a real difference for South Carolina students. Unsupported, fragmented programs do not meet the health and safety needs of our students or our society.

The preventable health problems of American children and adolescents continue to embarrass the nation and impede needed educational achievement. Large numbers of youth have emotional problems that often lead to poor performance, suicide, and risk-taking behaviors. Many turn to drugs and violence as a way of coping with life's challenges. Indiscriminate sexual behaviors expose many to exploitation, unplanned pregnancy, and sexually transmitted diseases. Many young people practice unhealthy nutrition and lead sedentary lifestyles.

Schools are in the business of preparing youth to be productive adults in tomorrow's world. However, to succeed in school—or in life—one must be healthy. It has long been acknowledged that health status affects how children learn, grow, and develop. Children and youth that are healthy are better able to benefit from learning experiences provided at home and in school. Comprehensive school health and safety education provides students with opportunities to develop the knowledge and skills necessary to practice a healthy lifestyle that enables them to become more successful students and adults. These standards provide a way of making the school program more responsive to student, family, and community needs. They provide a comprehensive approach to make good on past failures in school health programs.

Planned, sequential health and safety instruction as part of a comprehensive school health program for every student in South Carolina is an achievable goal. While not likely to be accomplished quickly, it can happen with careful curriculum planning; collaboration among school administrators, teachers, and members of the community; and a deep commitment to the health of our students and our state. In the next century, we should ensure that every student in South Carolina has the opportunity to receive a world-class education. This education should include the opportunity to become health literate.

“Comprehensive school health programs offer the opportunity for us to provide the services and knowledge necessary to enable children to be productive learners and to develop the skills to make healthy decisions for the rest of their lives”

--National School Boards Association 1997

GLOSSARY

HEALTH TERMS

ABSTINENCE. The denial of one's appetites; the conscious avoiding of pleasures that are thought to be harmful. To *abstain* is to refrain from something by one's own choice.

ADOLESCENT RISK BEHAVIORS. Behaviors identified by the Centers for Disease Control as being the most influential on the health of teenagers. These behaviors include tobacco use, eating patterns that contribute to disease, a lack of physical activity, sexual behaviors that result in HIV/STD infection and unintended pregnancy, alcohol and other drug use, and behaviors that result in injury.

COORDINATED SCHOOL HEALTH PROGRAM. An organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff that has traditionally included school health education, healthful school environments, and school health services. At a minimum, such a program should include school guidance and counseling, physical education, nutrition services, social work, psychological services, and employee health promotion (Joint Committee 1991, 103).

DEVELOPMENTALLY APPROPRIATE. Strategies that are suitable for, or consistent with, the age, growth, and developmental level of a student.

HEALTH. A state of complete physical, mental, and social well-being, not merely the absence of disease and infirmity (Joint Committee 1991, 100).

HEALTH EDUCATOR. A practitioner who is professionally prepared in the field of health education, who demonstrates competence in both theory and practice, and who accepts responsibility to advance the aims of the health education profession (Joint Committee 1991, 101).

HEALTH LITERACY. The capacity of an individual to obtain, interpret, and understand basic health information and services, and the competence to use such information and services in ways that are health enhancing (Joint Committee 1991, 102).

HEALTH EDUCATION STANDARDS. Standards that specify what students should know and be able to do. They involve the knowledge and skills essential to the development of health literacy. This knowledge includes the most important and enduring ideas, issues, and concepts in health education. These skills include the ways of communicating, reasoning, and investigating that characterize health education. Health education standards are not merely facts; rather they identify the

knowledge and skills that students should master to attain a high level of competency in health education.

HEALTHFUL SCHOOL ENVIRONMENT. The component of the coordinated school health program that includes a safe and health-enhancing physical environment, the organization of a healthful school day; an atmosphere that promotes respect and self-esteem; and the fostering of interrelationships that are favorable to social and emotional health (Montana 1993, 4).

LEARNING LOG. A record in which students communicate how and what they have understood about a concept or unit of study.

NUTRITION SERVICES. The component of the coordinated school health program that provides nutritionally balanced, quality, appealing meals that follow the *Dietary Guidelines for Americans* and reinforce the concepts taught in the instructional setting regarding the selection of healthy foods and the development of health-enhancing nutritional habits (Montana 1993, 4).

OPPORTUNITY-TO-LEARN STANDARDS. Descriptors that identify policies, resources, and activities to enable schools, communities, institutions of higher education, and state and national education agencies to support the implementation of the National Health Education Standards.

PARENT AND COMMUNITY INVOLVEMENT. An integrated approach to enhance the health and well-being of students. School health advisory councils, coalitions, and broad-based constituencies for school health can build support for program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students. Community involvement also provides the opportunity for students to engage in volunteer and service-learning activities that provide chances to extend practice of essential health and safety skills.

PHYSICAL EDUCATION. The component of the coordinated school health program that includes sequential prekindergarten through grade twelve curricula that provide a variety of developmental movement activities and health-related physical fitness programs to promote each student's optimum physical, mental, emotional, and social development and the development of physically active lifestyles.

RESPONSIBLE, PRODUCTIVE CITIZENS. Individuals who understand and carry out the obligation to ensure that their community is healthy, safe, and secure. They also recognize that this obligation begins with self, and they know that responsible individuals avoid behaviors that pose a health or safety threat to themselves or to others or that place an undue burden on society.

SCHOOL GUIDANCE AND COUNSELING. The component of the coordinated school health program that provides primary prevention and early intervention programs that attend to the mental, emotional, and social health of students.

SCHOOL HEALTH EDUCATION. The component of the school health program that addresses the dimensions of health and the development, delivery and evaluation of a planned, sequential curriculum and teaching strategies. Curriculum development includes the articulation of objectives, content sequence, and specific classroom lessons that draw from various content and topic areas to achieve learning standards and the broader-based student outcomes relating to health. School health education is designed to positively influence the health knowledge, attitudes, skills, and behaviors of individuals so as to promote health and prevent or reduce the risks of disease.

SCHOOL HEALTH EDUCATOR. A practitioner who is professionally prepared in the field of health education, meets state teaching requirements, and demonstrates competence and commitment in the development, delivery, and evaluation of health education curricula in a school setting. (Joint Committee 1991, 104).

SCHOOL HEALTH SERVICES. The component of the coordinated school health program that is provided by physicians, school nurses, dentists, and other allied health personnel, to appraise, protect, and promote the health of students and school personnel. These education personnel ensure access to and the appropriate use of primary health care services, prevent and control communicable disease, and provide emergency care for injury or sudden illness. They also promote sanitary conditions in a school facility and environment and often provide concurrent learning opportunities (Joint Committee 1991, 104).

SCHOOL SAFETY EDUCATION. The area of health education that deals with students' acquiring the knowledge and skills that will keep them safe from injury, accidents, and personal assault, as well as their learning what to do to prevent and treat injuries.

SCHOOL SITE HEALTH PROMOTION. The component of the coordinated school health program that provides health assessments, health education, and health-related fitness activities to encourage and assist all personnel in the development of health-enhancing behaviors. For faculty and staff it promotes better health, improved morale, and a greater personal commitment to the school's overall school health program.

SELF-DIRECTED LEARNER. Health-literate individuals are self-directed learners who have a command of the dynamic, changing health-promotion and disease-prevention knowledge base. They use literacy, quantitative, and critical-thinking skills to gather, analyze, and apply health information as their needs and priorities change throughout their lives. They also apply interpersonal and social skills in relationships to learn from and about others and, as a consequence, to grow and mature toward high-level wellness.

ASSESSMENT TERMS

The definitions in this section are adapted from *Promises to Keep: Creating High Standards for American Students*, the report to the National Education Goals Panel on the review of educational standards that was made by the Goals 3 and 4 Technical Planning Group (Wurtz et al. 1993).

ASSESSMENT. A collection of information used to evaluate student performance. Assessment information may include teacher observations, tests, writing samples, projects, research papers, class presentations, and performance tasks.

ASSESSMENT COMPONENT. A type of assessment instrument.

ASSESSMENT SYSTEM. The various pieces or components of the assessment process. This term may refer to formative and summative assessments or to assessments of different types or those conducted for different purposes.

CRITERION-REFERENCED. This type of assessment interpretation compares a student's response to a predetermined level of desired performance. Students' scores are expressed in terms of their meeting or not meeting the criterion or in terms of how far above or below the criterion the scores fall.

EXERCISE. An individual task or item to which a student responds.

EXTENDED RESPONSE. An exercise in which a student provides up to several paragraphs or more of extended text or other type of written response to a prompt or task.

FORMATIVE ASSESSMENT. These assessments, usually carried out at the classroom or school level, are used to guide the instruction of individual students.

INSTRUCTIONALLY EMBEDDED. A type of activity that takes place within the on-going classroom instruction. As used in assessment, this means a student activity, usually of some length (days or weeks) in which students engage in a hands-on learning activity that yields one or more products on which students can be scored, either collectively or individually.

INSTRUMENT. A set of exercises of one or more types that have known statistical properties and are to be used together to yield a broader set of information than at the individual exercise level.

LEARNING STANDARDS. Learning standards specify what students should know and be able to do. They involve the knowledge and skills essential to a discipline that students are expected to learn. These skills include the ways of thinking, working, communicating, reasoning, and investigating that characterize each discipline. This

knowledge includes the discipline's most important and enduring ideas, concepts, issues, dilemmas, and information. Learning standards are *not* merely lists of facts. Standards should be academically sound, broadly conceived, and assessable.

NORM-REFERENCED. This type of assessment interpretation compares a student's response to a comparison (or norm) group. Students' scores are expressed in terms of performance relative to the comparison group.

ON-DEMAND ASSESSMENT. These assessments are given to students in one relatively brief sitting, where they have not had an opportunity to rehearse their responses or to alter or improve their responses once they have given them.

PERFORMANCE INDICATOR. Performance indicators are more specific illustrations of the material and ideas implied by the learning standards. They state specific concepts and skills that fifth, eighth-, and eleventh-grade students should know and be able to do to demonstrate achievement of the health and safety education standards. Because the learning standards tend to be broad statements of intent, performance indicators will show specific applications of the standards in more measurable terms and for specific target content areas. Taken as a group, the performance indicators for a learning standard will demonstrate most but not all of the ways in which the learning standard can be further defined. They are intended to help educators focus on the essential knowledge and skills basic to the development of health-literate students. The performance indicators serve as a blueprint for organizing student assessment.

PERFORMANCE EVENT. An on-demand performance of some type, including written response, that calls for the student to respond within a relatively brief period of time (i.e., fifteen to forty-five minutes).

PERFORMANCE STANDARDS. These standards specify "how good is good enough." They indicate how adept or competent a student demonstration must be to indicate his or her attainment of the content standards. They involve judgments of what distinguishes an adequate from an outstanding level of performance. Student performance standards should establish the degree or quality of the student performance in the challenging subject matter set out in the content standards. Performance standards are *not* skills and modes of reasoning referred to in the learning standards. Rather, they indicate both the nature of the evidence (such as an essay, mathematical proof, scientific experiment, project, exam, or a combination of these) that is required to demonstrate that the content standard has been met. They also state the quality of the student performance that is deemed acceptable (that merits a passing or an A grade).

PERFORMANCE TASK. An exercise to which a student responds over a period of some time (i.e., several weeks). The exercise usually involves several parts and may require multiple activities and types of responses.

PORTFOLIO. Refers to the accumulation of student prompted and unprompted work within the classroom, as well as to the reflections of students, teachers, and others on this work. The folder may include standard tasks or one that the student selects, and it may include a variety of assessment results or other information. The intent is to portray both the current level of the student and the progress of the student over time.

SELECTED RESPONSE. An exercise in which the student selects one or more responses from among predetermined answers; often termed a “multiple-choice” item.

SHORT-ANSWER RESPONSE. An exercise in which a student provides a word, a phrase, a couple of sentences, or a diagram in response to a question.

SUMMATIVE ASSESSMENT. These assessments—which may be carried out at the school, district, state, or national level—serve the purpose of summarizing student performance on larger portions of learning at the end of major blocks of time.

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